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313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

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December 15, 2009

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF REPLACEMENT MEDI-CAL MANAGED CARE FUNDING AGREEMENT WITH L.A CARE HEALTH PLAN
(ALL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval of a replacement Medi-Cal Managed Care Program Services Agreement with LA Care to update terms and conditions and extend the period of funding.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Authorize the Interim Director of Health Services (Interim Director), or his designee, to execute a replacement Agreement with the Local Initiative Health Authority, otherwise known as L.A. Care Health Plan (L.A. Care), for the continued funding of health care provided by the Community Health Plan's (CHP) Medi-Cal Managed Care Program (MMCP), effective January 1, 2010 through September 30, 2012.

2. Delegate authority to the Interim Director, or his designee, to execute future amendments to the Agreement to: a) revise or incorporate provisions consistent with all applicable State law, regulations, and funding requirements, County Ordinance and Board policy changes, and accreditation standards; and, b) adopt or amend any Local Initiative Performance Standards and Policies and Procedures, subject to prior review and approval by County Counsel and the Chief Executive Office (CEO), with notification to your Board.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of the first recommendation will allow the Interim Director, or his designee, to execute an Agreement, substantially similar to Exhibit I, to replace Agreement No. H-703048 with L.A. Care in its entirety for the
continued funding of health care provided by CHP under its MMCP. Agreement No. H-703048 expired on September 30, 2009. However, L.A. Care has granted three consecutive one-month extensions to the Agreement, which is now slated to expire on December 31, 2009. The replacement Agreement is necessary as L.A. Care is requesting its plan partners to comply with required changes that the State Department of Health Care Services (SDHCS) implemented October 1, 2009. SDHCS implemented risk-based rates and new fee-for-service maternity rates, and eliminated a quality improvement program. These, and other changes, are described further in Attachment A. The replacement Agreement also contains a provision that allows L.A. Care to recoup the difference between the aggregate capitation payment actually made to CHP by L.A. Care for the period of October 1, 2009 through December 31, 2009 and any compensation which CHP would have been paid for the same period under the rates in the replacement Agreement.

Approval of the second recommendation will provide the Interim Director, or his designee, with an expedited process to amend the Agreement under certain conditions described above.

Implementation of Strategic Plan Goals

The recommended actions support Goal 4, Health and Mental Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The projected annual revenue reduction is $6.6 million during the first year of the rate changes (estimated at $3.3 million for Fiscal Year 2009-10), comparing the rates in the current agreement with the rates in the proposed agreement, and applied to the August 2009 enrollment profile. The fiscal impact of the new contract will be incorporated into DHS' next Fiscal Outlook update, scheduled for the January 19, 2010 Board agenda, and the FY 2010-11 budget request. Future FY's budgets will be adjusted as needed. Over the next three years, there are a number of factors which will impact CHP financial performance, including membership trends, revenue and cost, utilization, and network composition that will continue to be monitored and results reported in the DHS Fiscal Outlook.

L.A. Care has implemented only 20 percent of the risk adjustment in year one, consistent with the 20 percent implementation by the State. If the State proceeds with further implementation in years two and three, LA Care may adjust the rates to implement up to 60 percent of the risk adjustment in year two and 100 percent in the third year. L.A. Care will also recalculate the base risk adjustment each year, with updated data on the acuity of the population. Assuming that 1) L.A. Care fully implements the risk adjustments in years two and three, 2) there is no change in the number of enrollees assigned to CHP, and 3) there is no improvement or decline in CHP's calculated risk adjustment [either based on changes in the enrollee population or in the data used to calculate the risk profile], then CHP could see further revenue reductions in years two and three of $8 million per year [year 2 total reduction $14.6 million, and year three total reduction $22.6 million]. DHS is undertaking efforts to improve data capture to demonstrate a higher acuity population for CHP.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

CHP is a full-service State-licensed and federally-qualified Health Maintenance Organization (HMO) publicly operated by the County of Los Angeles and administered by DHS' Office of Managed Care. CHP's core business is the provision of health care to eligible members enrolled under CHP's MMCP, Healthy Families Program, and Personal Assistance Services Council-Service Employees International Union (PASC-SEIU) Homecare Worker Health Care Plan.

On February 11, 1997, your Board approved the Local Initiative Agreement / Medi-Cal Agreement with L.A. Care. On subsequent occasions, your Board approved a replacement Agreement No. H-207980, effective December 2002 and Amendments through September 30, 2008, and the current Agreement, H-703048, effective October 1, 2008 through September 30, 2009. L.A. Care has granted three consecutive one-month extensions to the current Agreement, which is now slated to expire on December 31, 2009.

In addition to the changes in payment methodology, the recommended replacement Agreement also includes the following new provisions:

• Centralized Provider Database: Adds language that establishes L.A. Care's centralized provider database as the controlling source of data concerning participating providers. Among other things, CHP will have real-time access for on-line CHP staff to make inquiries and generate reports.

• Self-Insurance Language: Adds self-insurance provisions consistent with the County's self-insurance program.

• Optional Benefits: Requires CHP to continue to offer certain optional Medi-Cal benefits discontinued by SDHCS for the benefit of CHP members. These benefits include audiology services, incontinence creams and washes products, annual optometric exams for diabetic members, podiatric services, and speech therapy.

• Capitation Recoupment: Adds language to enable L.A. Care to recover overpaid compensation during the extension period effective October 1, 2009 through December 31, 2009.

The Agreement complies with all applicable State laws and regulations. County Counsel has approved the Agreement as to use and form. Upon execution by both parties, a copy of the Agreement will be provided to each Board Office.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of these recommendations will ensure the continued funding of CHP's Medi-Cal Managed Care Program and will provide DHS with an expedited process to amend the Agreement under certain conditions with prior County Counsel and CEO approvals.

Respectfully submitted,

JOHN F. SCHUNHOFF, Ph.D.
Interim Director

JFS:kh

Enclosures

c: Chief Executive Officer
Acting County Counsel
Executive Officer, Board of Supervisors

Attachment A

Summary of Significant Changes to the

Replacement Medi-Cal Managed Care Funding Agreement

Risk-Based Rates

The State Department of Health Care Service (SDHCS) and L.A. Care both implemented the Medicaid Rx Pharmacy Risk Adjustor, which is a software application, to adjust rates based on the health risk of members as measured by pharmacy data. SDHCS ran the model to adjust the capitation rate for each of its directly contracted health plans. In turn, L.A. Care ran the model for each Plan Partner, and will annually, to phase-in the implemented rate adjustments due to the resulting risk score. L.A Care may implement the risk adjustment process in an incremental manner by applying such adjustments in an increasing percentage each year as follows:

1. For the Rate Year January 1, 2010 through September 30, 2010, the implementation factor shall be twenty percent (20%) or less;

2. For the Rate Year October 1, 2010 through September 30, 2011, the implementation factor shall be sixty percent (60%) or less, and

3. For the Rate Year October 1, 2011 through September 30, 2012, the implementation factor shall be one hundred percent (100%) or less.

Plan Partners with higher risk scores receive a rate increase while Plan Partners (including CHP) with lower risk scores receive a rate decrease.

Maternity Rates

SDHCS implemented the Maternity Supplemental Payment effective October 1, 2009 to reimburse L.A. Care and other State-contracted health plans a single rate per County for each maternity live delivery event. L.A. Care passed through the corresponding SDHCS capitation reduction to Plan Partners by means of reduced capitation rates, whereby each Plan Partner can recover the reductions by submitting maternity claims to L.A. Care.

Quality Incentive Program

SDHCS sunsetted the annual Quality Improvement Fee (QIF) on September 30, 2009. These fees were levied against L.A. Care and other State-contracted health plans in order to be used to draw down matching Federal monies. These matching Federal

funds were returned to the health plans through increased capitation rates paid by SDHCS. This generation of new funding through Federal matching amounted to capitation rate increases being awarded by SDHCS over the previous three contract years of approximately three percent (3%) annually. Due to the sunset of the QIF, there was no similar rate increase given by SDHCS for contract year 2009-10 (October 2009 – September 2010). In spite of this loss of funding, L.A. Care chose to continue its Quality Incentive Program. E-Health Initiative

L.A. Care is implementing certain e-Health Initiatives. CHP has agreed to spend a maximum of $100,000 to have its network providers participate in L.A. Care's Pharmacy e-Prescribing Initiative, which will provide appropriate electronic access to CHP Member eligibility, medication history, and formulary information to enable these providers to electronically send prescriptions directly to the pharmacy.

Services Agreement
between
Local Initiative Health Authority
for Los Angeles County
and
COMMUNITY HEALTH PLAN

This Services Agreement ("Agreement") is entered into this _____day of _____, 20___ by and between the Local Initiative Health Authority for Los Angeles County, a local governmental agency ("Local Initiative"), and **Community Health Plan,** a California health care service plan ("Plan").

RECITALS

WHEREAS, the state of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, Local Initiative has been designated as Los Angeles County's locally created health care service plan by the Los Angeles County Board of Supervisors. It is a public entity, created pursuant to Welfare and Institution Code Sections 14087.38(b) and 14087.9605 and Los Angeles County resolution and ordinance;

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act; (Health and Safety Code Sections *1340 et seq*.) (the "Knox-Keene Act").

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries;

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated January 1, 2008, as amended, for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the requirements of the Medi-Cal Agreement and all applicable federal and state laws; and

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree as follows:

ARTICLE I.
DEFINITIONS

1.01 "Actual Risk Factors" means Plan's or Local Initiative's computed scores based on members' inpatient, outpatient, physician or pharmacy encounters designed to measure the relative risk due to the members' health status. Local Initiative shall utilize either Medicaid Rx, a pharmacy based risk adjustment system, or the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, (both systems offered by the University of California, San Diego) at its sole discretion, to determine the Risk Factors. Local Initiative and Plan shall meet and confer regarding the impact of the CDPS Risk Adjustment System, prior to Local Initiative's implementation of that system.

1.02 "Board of Governors" means the duly appointed governing body of the Local Initiative.

1.03 "Business Associate" shall have the meaning given to such term under the HIPAA regulations, including but not limited to, 45 C.F.R. Section 160.103.

1.04 "Capitation Payment" means the fixed monthly payment that is payable to Plan by Local Initiative for each Plan Member.

1.05 "Delegated Activities" shall mean those Health Care services and related functions which Local Initiative has delegated to Plan pursuant to the Delegation Agreement.

1.06 "Delegation Agreement" means that agreement entered into between Local Initiative and Plan and incorporated into this Agreement in which Plan has agreed to accept delegation from Local Initiative to provide certain health services and functions which Local Initiative would be otherwise obligated to provide under the Medi-Cal Managed Care Program in order to comply with NCQA standards.

1.07 "DHCS" means the California Department of Health Care Services.

1.08 "Disproportionate Share Hospital" means any hospital receiving payments as provided in California Welfare and Institutions Code Section 14105.98.

1.09 "DMHC" means the California Department of Managed Health Care.

1.10 "Eligibility List" means the list of all Plan Members to be provided to Plan on a monthly basis by Local Initiative.

1.11 "Emergency Medical Condition" shall have the meaning as provided either in applicable statutes or regulations and/or the Medi-Cal Agreement and subject to later amendment by

the aforementioned sources, the later of which defines emergency medical condition to mean a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent lay person, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily function, or
3. Serious dysfunction of any bodily organ or part.

1.12 "Emergency Services" means those health services needed to evaluate or stabilize an Emergency Medical Condition, including those emergency services defined in applicable provisions of the California Health & Safety Code and Title 22 and Title 28 of the California Code of Regulations.

1.13 "Federally Qualified Health Center" means a federally qualified health center as defined in Section 1905(1)(2)(B) of the Social Security Act.

1.14 "Health Care Services" means all medical, hospital and other services, including Emergency Services and Urgent Care Services, which are covered benefits under the Local Initiative Medi-Cal Plan.

1.15 "Insolvent" or the condition of "Insolvency" means that the Local Initiative, Plan or any Plan Participating Provider, as applicable, (i) generally fails to pay or admits in writing its inability to pay its debts as they become due, subject to applicable grace periods, if any, whether at stated maturity or otherwise; (ii) fails to maintain the financial reserves required under the Medi-Cal Agreement, this Agreement or applicable law; (iii) voluntarily ceases to conduct its business in the ordinary course; (iv) commences any insolvency proceeding with respect to itself; (v) takes any action to effectuate or to authorize an insolvency proceeding with respect to itself; or (vi) fails to contest any such insolvency proceeding.

1.16 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated thereunder by the United States Department of Health and Human Services ("DHHS") and other applicable laws.

1.17 "Local Initiative Medi-Cal Plan" means Local Initiative benefit plan covering the provision of Health Care Services to Medi-Cal Members pursuant to the Medi-Cal Agreement. The benefit schedule for the Local Initiative Medi-Cal Plan is as set forth in the Medi-Cal Agreement and includes all services for which Local Initiative receives capitation payments under the Medi-Cal Agreement.

1.18 "Knox-Keene Act" means the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the rules and regulations promulgated by DMHC thereunder.

1. 19 "Medi-Cal" means the federal and state funded health care program established by Title XIX of the Social Security Act, as amended, which is administered in California by the DHCS.

1.20 "Medi-Cal Agreement" means the agreement entered into by and between Local Initiative and DHCS under which Local Initiative has agreed to arrange for or provide health benefits under the Medi-Cal Managed Care Program to Medi-Cal beneficiaries who may enroll in the Local Initiative Medi-Cal Plan. A copy of the Medi-Cal Agreement will be provided to Plan by Local Initiative upon execution and will be incorporated herein by reference. The required elements of this Agreement will, among other things, conform with the Medi-Cal Agreement.

1.21 "Medi-Cal Member" means an individual who is eligible for Medi-Cal and is enrolled in the Local Initiative Medi-Cal Plan.

1.22 "Medically Necessary" means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

1.23 "Monthly DHCS Payment" means the revenue received by Local Initiative each month from DHCS, as determined by DHCS, for the Health Care Services each Medi-Cal Member is to be provided under the Local Initiative Medi-Cal Plan.

1.24 "Normalized Risk Factors" means Actual Risk Factors, as defined herein, of Plan adjusted proportionately to the Actual Risk Factor of the Local Initiative so that Local Initiative's Normalized Risk Factor becomes 1.00, with the Plan Actual Risk Factor adjusting accordingly. Normalized Risk Factors and Actual Risk Factors are, sometimes, herein collectively referred to as "Risk Factors."

1.25 "NCQA" shall mean the National Committee for Quality Assurance.

1.26 "Plan Participating Physician" means a licensed physician or osteopath or group of physicians or osteopaths which has contracted with or is employed by Plan to provide or arrange Health Care Services to Plan Members.

1.27 "Plan Member" means a person enrolled in the Local Initiative Medi-Cal Plan who has been assigned to or selected Plan and who has been assigned to or selected a Plan Participating Physician as his or her Primary Care Physician.

1.28 "Plan Participating Physician" means a licensed physician or osteopath or group of physicians or osteopaths which has contracted with or is employed by Plan to provide or arrange Health Care Services to Plan Members.

1.29 "Plan Participating Providers" means Plan Participating Physicians, hospitals and other facilities and providers, such as ancillary service providers, which are owned and operated by Plan or which contract with Plan to provide Health Care Services to Plan Members.

1.30 "Plan Partner" means Plan or any other health care service plan licensed under the Knox-Keene Act, which has entered into a Services Agreement with Local Initiative to provide or arrange for Health Care Services to Medi-Cal Members and to perform the other duties and responsibilities as set forth in such Plan Partner's Services Agreement with Local Initiative.

1.31 "Plan Service Area" means the geographic area in which, as of the commencement date of this Agreement, Plan is licensed to provide or arrange for Health Care Services in the State of California by the DMHC. The Plan Service Area is described in Exhibit 1, attached hereto and incorporated herein. The Plan Service Area may be revised by mutual consent of the parties subject to approval of DMHC and DHCS.

1.32 "Plan Subcontracts" means the contracts entered into between Plan and its Participating Providers for the performance and arrangement of Health Care Services.

1.33 "Primary Care Physician" means a physician who: i) has focused the delivery of medical care to general practice or is a board-certified or board-eligible internist, pediatrician, family practitioner or obstetrician/gynecologist; and ii) has been selected by or assigned to a Medi-Cal Member for the purpose of, and who is responsible for, coordinating Health Care Services under the Local Initiative Medi-Cal Plan for such Medi-Cal Member, including without limitation, supervising and providing primary care to the Medi-Cal Member, initiating referrals for specialist care, and maintaining continuity of care.

1.34 "Proprietary Information" shall mean any technical or business, written, graphic, electronic, oral or other tangible information including, but not limited to, the Eligibility List, and is information that is generally unavailable to the public and has been developed by either party to this Agreement, and has economic value to the business in which that party is engaged.

1.35 "Protected Health Information" means any information, whether oral or recorded in any form or medium (i) that relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA, including, but not limited to, 45 C.F.R. Section 164.501.

1.36 "Safety Net Provider" means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant number of

medically indigent patients in relation to the total number of patients served by the provider, as further defined from time to time by the Board of Governors and approved by DHCS.

1.37 “Supplemental Health Care Services” means all medical, hospital and other services which are benefits which Local Initiative requires Plan to cover, but which are not included in the benefit schedule set forth in the Medi-Cal Agreement.

1.38 "Tobacco Lawsuit" means that lawsuit filed by DHCS and more commonly known as “People of the State of California ex rel. Daniel E. Lungren, Attorney General of the State of California; S. Kimberly Belshe, Director of Health services of the State of California v. Philip Morris, Inc. et. al.”

1.39 "Traditional Provider" means any hospital, physician, or other facility or medical provider which has historically delivered services to Medi-Cal beneficiaries as further defined from time to time by the Board of Governors and approved by DHCS.

1.40 "Urgent Care Services" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

ARTICLE II
ORGANIZATIONAL ACTIVITIES/
JOINT RESPONSIBILITIES

2.01 Plan Commitment to Local Initiative.

(a) Local Initiative Mission, Vision and Values. Local Initiative is committed to providing Medi-Cal Members coordinated, quality, culturally and linguistically sensitive Health Care Services in accordance with the requirements of the Medi-Cal Agreement, the Knox-Keene Act and other applicable legal requirements. As part of the fundamental consideration for this Agreement, Plan shall abide by and support the mission, vision and values of the Local Initiative as articulated from time to time by the Local Initiative Board of Governors and consistent with the terms of this Agreement.

(b) Exclusivity. During the term of this Agreement, except as set forth below in the case of Plan becoming the Medi-Cal Commercial Plan for Los Angeles County, Plan shall not directly or indirectly participate in the Medi-Cal Commercial Plan for Los Angeles County, unless Local Initiative consents in advance in writing. For purposes of this Section 2.01(b), direct or indirect participation shall include, but not be limited to, Plan entering into a contract with DHCS to become the Medi-Cal Commercial Plan for Los Angeles County, or entering into a subcontract with the Medi-Cal Commercial Plan for Los Angeles County. Plan understands and agrees that any exclusive contract entered into by Plan with any provider for the provision of Health Care Services to Medi-Cal beneficiaries is prohibited pursuant to Section 10.23(b).

Furthermore, Plan shall not enter into a contract with DHCS to become the Medi-Cal Commercial Plan for Los Angeles County unless and until both of the following conditions occur: 1) Plan has provided Local Initiative no less than six (6) months notice between the time of entering into a contract with DHCS to become the Medi-Cal Commercial Plan for Los Angeles County and the time the Plan commences operations pursuant to that contract; and 2) all Medi-Cal Members assigned to Plan have been transitioned from Plan in accordance with Local Initiative's directives. Either Plan's election to enter into a contract with DHCS to become the Medi-Cal Commercial Plan for Los Angeles County prior to satisfying the two (2) conditions set forth above, Plan's election to enter into a subcontract with the Medi-Cal Commercial Plan of Los Angeles County or any violation of this Section 2.01(b) shall be deemed to be a breach of a material term, covenant or condition by Plan and, as such, the termination provisions set forth in Section 7.02(b), as well as any other legal or equitable remedy available to Local Initiative, shall apply. In the event Plan enters into a contract with DHCS to become the Medi-Cal Commercial Plan for Los Angeles County subsequent to satisfying the two (2) conditions set forth above, Local Initiative may terminate this Agreement pursuant to Section 7.02(h). Plan warrants to Local Initiative that it will assist and cooperate with Local Initiative efforts to transition such Medi-Cal Members and will otherwise utilize best efforts to ensure continuity of care the adequate provision of Health Care Services to such members during any transition.

2.02 Plan Liaison. The Plan Liaison shall be an individual designated by Plan in writing who shall be responsible for supervising, coordinating and overseeing Plan's performance of its duties and responsibilities under this Agreement. The Plan Liaison shall act as Plan's agent for the purposes of this Agreement and, in such capacity, be authorized to represent and legally bind Plan with respect to all matters relating to Plan's rights and obligations and performance of its duties and responsibilities under this Agreement. Plan may change the Plan Liaison upon written notice to Local Initiative. The Plan Liaison, or a substitute representative with the same authority, shall meet with Local Initiative staff as reasonably requested by the Local Initiative Chief Executive Officer, or his or her designee, to assist with the coordination, implementation and operation of the Local Initiative Medi-Cal Plan and Plan's performance under this Agreement.

2.03 Interaction with DHCS and DMHC.

a) Local Initiative Interaction. Local Initiative shall be responsible for all required interactions with DHCS and DMHC with respect to the Local Initiative Medi-Cal Plan. The parties understand and acknowledge that the nature and scope of services for which Local Initiative may contract with Plan is subject to DHCS and DMHC approval. Local Initiative may invite Plan participation in interactions with DHCS and DMHC whenever Local Initiative deems necessary. Notwithstanding the foregoing, Plan shall coordinate with Local Initiative regarding any communications to DMHC concerning Plan's Medi-Cal product as well as give Local Initiative either prior notice or notice within five (5) business days of any such communication. The foregoing notice requirement shall not apply to any non-material and routine Plan filing with DMHC. The parties understand and agree that nothing in this Section shall in any way prohibit or restrain Plan from communicating with DMHC directly regarding any regulatory requirement.

b) Plan Information. In the event information is needed from Plan in order to respond to any inquiries, complaints, or requests for corrective action made by DHCS or DMHC to Local Initiative, Local Initiative shall notify the Plan Liaison of the needed information as expeditiously as possible. Plan shall provide the information requested to Local Initiative within such time period as may be necessary to enable Local Initiative to respond to DHCS or DMHC within the time frames imposed by the regulatory agency for Local Initiative's response. Plan shall cooperate fully and as necessary to resolve any inquiries, complaints, grievances and legal actions involving the performance or failure of performance by either party under this Agreement.

c) Agency Inquiries/Complaints against Plan. Plan shall notify Local Initiative within five (5) business days of the receipt of any DHCS or DMHC inquiries, complaints, requests for corrective action, deficiency notices, cease and desist orders or legal actions relating to Plan's provision of Health Care Services to Plan Members under this Agreement or relating to any other aspect of Plan's performance under this Agreement.

ARTICLE III
LOCAL INITIATIVE RESPONSIBILITIES

3.01 Medi-Cal Agreement. Local Initiative shall obtain the Medi-Cal Agreement and maintain it in effect throughout the term of this Agreement. Local Initiative shall be responsible for administering the Medi-Cal Agreement.

3.02 Knox-Keene Licensure. Local Initiative shall remain a licensed health care service plan in good standing with the DMHC.

3.03 Local Initiative Members. Plan understands and acknowledges that Plan Members are enrolled through Local Initiative and are members of the Local Initiative Medi-Cal Plan.

3.04 Trade Names. Local Initiative has developed a trade name and a trademark for usage with respect to the Local Initiative Medi-Cal Plan. To the extent permitted by DMHC and applicable laws and regulations, and subject to Local Initiative's prior approval, Plan shall use such trade name and trademark on all materials relating to the Local Initiative Medi-Cal Plan. Local Initiative shall have the right to use Plan's trade name and trademarks in all Local Initiative marketing, enrollment and other materials in order to identify Plan as a Plan Partner of Local Initiative. Local Initiative's use of Plan's trade name and trademarks shall be subject to Plan's prior approval.

3.05 Enrollment/Disenrollment.

(a) Enrollment and Assignment. Local Initiative shall be responsible for processing all Medi-Cal Member enrollments in coordination with the DHCS-designated health care options contractor (or such other enrollment organization or process as may be designated by DHCS from time to time), and in accordance with applicable state and federal laws and the Medi-Cal Agreement. As part of the enrollment process, each Local Initiative Medi-Cal Member shall have the opportunity to select enrollment with any Plan Partner and/or, through Local Initiative or Plan as determined by Local Initiative, to select assignment to any Primary Care Physician contracting with a Plan Partner within the first thirty (30) calendar days of enrollment, subject to the capacity limits of either the Plan Partner or Primary Care Physician. Plan understands and acknowledges that if a Medi-Cal Member desires to select a Plan Participating Physician who also is a contracting provider with another Plan Partner, the Medi-Cal Member shall have the option to select enrollment with either Plan Partner. As long as Local Initiative directly provides or arranges for the provision of Health Care Services pursuant to the provisions of Section 3.13 herein, Medi-Cal Members also shall be able to select or be assigned to Local Initiative and its contracting providers.

In the event a Medi-Cal Member does not select enrollment with a Plan Partner and/or assignment to a Plan Participating Primary Care Physician, Local Initiative shall be responsible for assigning such Medi-Cal Member to a Plan Partner and/or, through Plan, a Plan Participating Primary Care Physician (or to Local Initiative and a Local Initiative Primary Care Physician in the event Local Initiative directly provides or arranges for the provision of Health Care

Services). Local Initiative shall adopt policies and procedures governing such assignment process consistent with the principles set forth in Section 3.05(e) herein.

(b) Member Number. The Local Initiative member identification number for each Medi-Cal Member shall be the unique Medi-Cal identification number assigned to such Medi-Cal Member by DHCS. Plan and Plan Participating Providers shall not sell or, except as necessary to perform its duties and responsibilities hereunder, disclose Plan Members' Medi-Cal identification numbers to any third party.

(c) Transfers. Plan shall cooperate with Local Initiative in arranging Plan Member transfers on a timely basis in the event a Plan Member requests a transfer to a different Plan Partner (or a participating provider of such Plan Partner) or in the event a Medi-Cal Member who is not currently a Plan Member requests a transfer in order to select Plan and a Plan Participating Physician as the Plan Member's Primary Care Physician. Plan shall notify Local Initiative within five (5) business days of receipt by Plan of any Plan Member request for transfer. Plan shall comply, and shall ensure its Plan Participating Providers comply, with Local Initiative transfer policies and procedures as implemented from time to time.

(d) Disenrollments. DHCS shall be responsible for processing all Medi-Cal Member disenrollments, and Local Initiative and Plan shall cooperate in such disenrollment process in accordance with applicable state and federal laws, DHCS requirements, and the Medi-Cal Agreement. Plan shall notify Local Initiative of any Plan Member requests for disenrollment that Plan has knowledge of on a monthly basis. Plan shall ensure that its Participating Providers comply with the DHCS disenrollment procedure requirements as implemented from time to time, including, without limitation, any time frames for reporting circumstances under which Plan Member disenrollment is legally required. Plan shall establish a procedure for Plan initiated disenrollments which shall comply with the Medi-Cal Agreement and which shall be approved by Local Initiative and DHCS. Neither Plan nor any Plan Participating Provider shall interfere with or inhibit the right of any Plan Member to timely disenroll from the Plan at the Plan Member's option, or as otherwise required, in accordance with applicable federal and state law and regulation, DHCS requirements and the Medi-Cal Agreement.

(e) Enrollment Targets. The Maximum Enrollment Target for Plan, set forth on Exhibit 2 hereto, reflects the maximum number of Medi-Cal Members in mandatory aid codes that Local Initiative is obligated to enroll with Plan under this Agreement. Medi-Cal Members enrolled with Plan in non-mandatory aid codes or who chose or are assigned to the Los Angeles County Department of Health Services ("LACDHS") health care delivery system pursuant to a subcontract between Plan and LACDHS as a Plan Participating shall not be counted toward Plan's Maximum Enrollment Target. (For the purposes of this Agreement, "mandatory aid codes" means the aid codes designated by DHCS and approved by the United States Centers for Medicare and Medicaid Services ("CMS") for mandatory enrollment in either the Local Initiative Medi-Cal Plan or the Commercial Plan.) Enrollment of Medi-Cal Members in mandatory aid codes in excess of Plan's Maximum Enrollment Target shall be in Local Initiative's Board of Governors sole discretion. There shall be no limit on the number of Medi-Cal Members in non-mandatory aid codes, which may be enrolled, with Plan as Plan Members, subject to any capacity limits of Plan and Plan Participating Providers.

Plan understands and acknowledges that the Maximum Enrollment Target does not constitute a guarantee of any specific enrollment amount or time frame for enrollment for Plan. Actual enrollment of Medi-Cal members with Plan may be limited due to Plan or Plan Participating Physician capacity limits being met in specific geographic areas, Local Initiative imposition of enrollment freezes or other sanctions upon Plan or Plan Participating Providers pursuant to the provisions of this Agreement, Medi-Cal Member selection preferences, DHCS enrollment delays or other factors. With respect to the process for assignment of Medi-Cal Members to a Plan Partner when the Medi-Cal Member either does not select enrollment with a Plan Partner and/or assignment to a Primary Care Physician as provided in Section 3.05(a) herein, the Local Initiative Medi-Cal Member assignment policies and procedures shall first take into account the following factors including but not limited to: (i) the geographic and other needs of the specific Medi-Cal Member; (ii) default assignment of Medi-Cal Members to Community Health Plan in each region in which Plan meets all of the conditions and requirements for enrollment of Medi-Cal members under the Services Agreement by and between Community Health Plan and Local Initiative, as necessary to implement the enrollment provisions set forth in Section 3.05(e) of such Services Agreement by and between Plan and Local Initiative; (iii) the extent to which Plan's Plan Participating Providers are Traditional and Safety Net Providers; and (iv) maintenance of the same ratio that Plan's then current Maximum Enrollment Target bears to the total of the then current Maximum Enrollment Targets of all of the Plan Partners.

Plan may request an increase in its Maximum Enrollment Target at any time; provided, however, that any request to increase Plan's Maximum Enrollment Target above 200,000 Medi-Cal Members shall be subject to the Local Initiative's determination that additional overall enrollment capacity for Local Initiative Medi-Cal Members is needed. Subject to the foregoing, the Local Initiative Chief Executive Officer shall recommend approval of the Plan's request to increase its Maximum Enrollment Target to the Local Initiative Board of Governors, so long as Plan has sufficient provider and administrative capacity for the requested increase and the Plan is in compliance with the terms and condition of this Agreement, including without limitation, having all necessary regulatory approvals and meeting or exceeding the Local Initiative then current performance standards. Any request for an increase in the Plan's Maximum Enrollment Target shall be decided by the Local Initiative Board of Governors in its sole discretion.

(f) Enrollment Limitation Due To Insolvency. Notwithstanding any other provision of this Agreement, in the event that Local Initiative shall determine, that pursuant to Section 1.15 herein, the Plan is Insolvent or in the condition of Insolvency, then Local Initiative may take such action as it deems appropriate to limit the further enrollment of Medi-Cal Members in the Plan or to cause the disenrollment or transfer of Medi-Cal Members from the Plan. Such actions by Local Initiative may include, without limitation, providing information to Medi-Cal Members concerning the status of the Plan, encouraging Medi-Cal Members to request a transfer from the Plan, modifying any target or enrollment goal contained herein, ceasing the further enrollment of Medi-Cal Members with the Plan notwithstanding any other provision hereof, or processing the transfer of Medi-Cal Members from the Plan with the consent of the Medi-Cal Members. In adopting this approach, it is Local Initiative's intent to enhance continuity of care for affected Medi-Cal Members.

3.06 Verification of Eligibility. Within five (5) business days after receipt of the monthly eligibility list from DHCS, Local Initiative will provide to Plan a copy of the Eligibility List listing the Plan Members based on DHCS information. Such Eligibility List shall be provided to Plan using the DHCS electronic data transmission format unless Local Initiative and Plan mutually agree on an alternative electronic data transmission in accordance with a HIPAA compliant, industry standard format.

3.07 Local Initiative Marketing. The Local Initiative, with input from the Plan Partners as Local Initiative deems appropriate, shall develop and make decisions relating to Local Initiative marketing and promotional materials and programs. Plan shall conduct any marketing activities with respect to Medi-Cal Members only with Local Initiative's prior approval and in compliance with all applicable federal and state requirements, including without limitation, the Knox-Keene Act, laws and regulations of the Medi-Cal Program, including Title 22, California Code of Regulations, Section 53880. Plan shall not engage in marketing practices that discriminate against an eligible beneficiary because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap or health status. Local Initiative shall approve, prior to use, any marketing programs or materials developed by Plan with regard to Plan's services to Plan Members or otherwise with regard to Plan's participation in the Local Initiative Medi-Cal Plan. The parties specifically agree that all marketing programs and materials will be subject to all required regulatory approvals. Plan understands and agrees that in no event shall door-to-door or other point of sale marketing to or solicitation of Medi-Cal Members be permitted.

3.08 Quality Management Program. Local Initiative shall implement a quality management program for application to Medi-Cal Members in accordance with the requirements of DHCS and DMHC. The Local Initiative quality management program, which shall include a quality improvement plan, will monitor, evaluate and take effective action to address identified problems and any needed improvements in the quality of care delivered to Medi-Cal Members and will ensure Local Initiative accountability for any quality management activities delegated to Plan. Mechanisms for such monitoring and evaluation shall include, without limitation, Local Initiative surveys (including member and provider satisfaction surveys), site visits, audits, development and implementation of quality improvement goals and targets, and review of Plan regulatory agency survey reports, as more fully set forth in the Local Initiative quality management program and related policies and procedures.

Local Initiative shall maintain quality management committees and sub-committees which shall be responsible for oversight of all Health Care Services provided to Medi-Cal members. The Plan Chief Medical Officer, or his or her designee, shall serve on the Local Initiative quality management committees. Upon Local Initiative request, Plan shall provide Local Initiative with a list of appropriately qualified Plan Participating Providers who will be available to serve, as reasonably requested by Local Initiative, on Local Initiative quality management sub-committees.

The Local Initiative quality management plans, and any amendments thereto, shall be reviewed by the Local Initiative quality management committees prior to adoption and implementation by Local Initiative and shall thereafter be distributed to Plan upon request. Plan

and its Plan Participating Providers shall comply with and participate in the Local Initiative quality management plan activities, pursuant to the standards and procedures set by Local Initiative, including, without limitation, participation in and performance of quality of care studies, research concerning quality of care and delivery of care issues, and audits to determine compliance with Local Initiative, DHCS and DMHC standards, guidelines and quality indicators. Plan shall undertake on-going quality management activities with regard to Health Care Services rendered to Plan Members as set forth in Section 4.08.

3.09 Plan Member Grievance/Appeal Procedure. Local Initiative and Plan will implement a grievance and appeals process, respectively, for the review of Plan Member clinical and non-clinical grievances which shall meet the unique needs of Medi-Cal beneficiaries and comply with the time limit and other requirements of DHCS and DMHC. Plan shall undertake on an ongoing basis review of Plan Member grievances by utilizing the Plan grievance procedure. The Plan grievance procedure, including applicable grievance forms, which is applicable to Plan Members, and any amendments thereto, shall be approved in advance by Local Initiative. If a grievance is not resolved to the Plan Member's satisfaction through the Plan grievance procedure within the time specified in the Medi-Cal Agreement or as required by law, Plan shall document reasonable efforts to resolve the complaint, and the Plan Member shall have the right to appeal the grievance through a Local Initiative grievance appeals process, which shall be binding on Plan and Plan Member (subject to any Plan Member fair hearing or other appeal rights under applicable federal and state laws and regulations), as adopted and amended by Local Initiative from time-to-time. The grievance and appeal procedures shall provide that Local Initiative shall have the authority, at the election of Local Initiative, to directly undertake or complete the initial review of a Plan Member's grievance in the event the Plan's grievance review is not completed in accordance with any requirements, including without limitation any time frames, imposed by DHCS or DMHC. The Plan grievance procedure also shall include a grievance process for Plan Participating Providers. The Plan grievance procedure shall obligate Plan to notify Local Initiative of all grievances within the timeframes set forth in Local Initiative policies and procedures. Amendments to the Plan Grievance Procedure and the Local Initiative appeals procedure shall be subject to all necessary approvals from DHCS and DMHC.

Local Initiative is hereby designated by Plan as an additional agent in Plan's grievance program for the purpose of: (1) receiving and forwarding to Plan any Plan Member or provider information relevant to the grievance; (2) upon request of Plan, facilitating in the resolution of the grievance; and, (3) assisting in the monitoring of the grievance process. In the conduct of such activities, information and reports relating to Plan Members and the quality of care rendered to them may, from time to time, be provided by Plan to Local Initiative. It is specifically understood and agreed that the conduct of the activities described hereunder will at all times comply with any and all laws relating to the confidentiality of medical information and will preserve all privileges as set forth in California Health and Safety Code Section 1370.

3.10 Plan Grievance/Appeal Procedure. Local Initiative shall implement and maintain a grievance system for the review of Plan grievances, which shall be in accordance with Local Initiative policies and procedures, as well as with the requirements of DMHC and DHCS. In the

event the grievance is not resolved to the satisfaction of the Plan, Plan may elect to proceed under Section 10.07 of this Agreement.

3.11 Utilization Management Program. Local Initiative shall develop, implement and maintain a utilization management program in accordance with the requirements of DHCS and DMHC. The utilization management program shall be distributed to Plan. Local Initiative shall ensure that the utilization management program has mechanisms to detect both under and over-utilization of services, and to monitor appropriateness of approval and denials of payment for Health Care Services, consistent with the Local Initiative quality management program and related policies and procedures. The Local Initiative utilization management program shall provide for monitoring of Plan's utilization management activities and shall ensure Local Initiative accountability for any utilization management activities delegated to Plan. Plan and its Plan Participating Providers shall cooperate with and participate in Local Initiative utilization management activities, including, without limitation, reporting utilization management information to Local Initiative as requested by Local Initiative.

3.12 Public Advisory Committees. Local Initiative has established Public Advisory Committees consisting of Local Initiative Medi-Cal Members, member advocates, providers and other interested parties to assist Local Initiative in fulfilling its mission, vision and values and to provide input to assist Local Initiative in its oversight of the Local Initiative Medi-Cal Plan. These Public Advisory Committees include, but are not limited to, the Technical Advisory Committee, Children's Health Consultant Advisory Committee, Executive Community Advisory Committee, and Regional Community Advisory Committees. Plan shall cooperate with the Public Advisory Committees as reasonably requested by Local Initiative.

3.13 Local Initiative Provision of Health Care Services. Local Initiative shall have the ongoing right to directly provide or arrange for the provision of Health Care Services to Medi-Cal Members upon receiving specific approval from the Local Initiative Board of Governors, (for purposes of this Section, collectively referred to as "Board"); such approval must be granted as an official act of the Board pursuant to the Board's then current bylaws. Prior to granting such approval, the Board shall provide all interested parties an opportunity to present their concerns to the Board. The Board shall make its decision based upon the best interests of the Local Initiative Medi-Cal Members, Plan Participating Providers, Plan Partners and the Local Initiative. Absent exigent circumstances, determination of which will be in the sole, commercially reasonable discretion of Local Initiative, Plan shall receive at least thirty (30) calendar days notice prior to the Board rendering its decision regarding Local Initiative's direct provision or arrangement for the provision of Health Care Services to Medi-Cal Members. Local Initiative's direct provision or arrangement for the provision of Health Care Services shall be subject to all required DHCS and DMHC approvals. As used in this Agreement, the phrase "directly provide or arrange for the provision of Health Care Services to Medi-Cal Members" shall exclude, among other things, any arrangement, venture, partnership, agreement or other business relationship between Local Initiative and Community Health Plan and/or the County of Los Angeles; any arrangement, venture, partnership, agreement or other business relationship between Local Initiative and any other entity which, at the time of the commencement of the relationship, is neither a Plan Partner, as defined herein, nor that Plan Partner's successor in interest, debtor in possession, or parent

organization; or any arrangement regarding non-Medi-Cal Members. Pursuant to this Section 3.13, Local Initiative has exercised its right to and is directly providing or arranging for the provision of Health Care Services to Medi-Cal Members. Further, nothing in Section 3.13 or in this Agreement shall prevent Local Initiative from exercising this right on an ongoing basis in accordance with and pursuant to Section 3.13.

3.14 Performance Standards. Local Initiative shall adopt and amend performance standards and policies and procedures from time to time as necessary in order to implement the Local Initiative Medi-Cal Plan, which shall become binding upon Plan and Plan Participating Providers in accordance with the provisions of Sections 10.05 and 10.06 herein. The Local Initiative performance standards shall delineate reasonable goals for performance by Plan Partners and Plan Participating Providers and will establish measurable thresholds to determine compliance or non-compliance with such performance standards. The Local Initiative performance standards shall be adopted and amended in Local Initiative's reasonable discretion after providing a reasonable opportunity for input thereon from its Plan Partners.

3.15 Incentive Programs. Local Initiative may develop and implement incentive programs to encourage the provision of coordinated, quality, culturally and linguistically sensitive Health Care Services. Local Initiative will implement such incentive programs pursuant to the adoption of policies and procedures, which shall become binding upon the Plan and Plan Participating Providers in accordance with the provisions of Sections 10.05 and 10.06, herein. The incentive programs may provide for the payment of compensation in addition to that otherwise provided for under this Agreement, or the use of other incentive methods, to the Plan or to the Plan Participating Providers. In no instance shall an incentive program implemented pursuant to this section result in a decrease or increase of the Capitation Payment due to Plan pursuant to Sections 6.01 and 6.02, herein.

3.16 Temporary Services. Local Initiative shall provide Plan with access to Local Initiative's temporary services contract(s) to assist Plan in claims processing and adjudication, member services functions, utilization review, MIS operations and other functions as may be subsequently agreed to by the parties. Local Initiative shall bill Plan for such services at cost. Local Initiative's obligation to provide Plan access to Local Initiative's temporary services contract(s) shall expire upon one hundred eighty (180) calendar days prior written notice of one party to the other or upon termination of this Agreement, whichever is earlier. Notwithstanding the 180 days notice provision set forth above, any failure by the Plan to reimburse L.A. Care in a timely manner for any expenses incurred related to this provision or any failure to reasonably assist L.A. Care in complying with the terms and conditions of a temporary services contract accessed pursuant to this provision will result in termination of this provision upon ten (10) calendar days written notice. Further, Plan is required to give notice in writing or by electronic mail ("email") to Local Initiative's Chief of Human Resources within ten (10) calendar days of accessing a Local Initiative temporary services contract.

3.17 Plan Participating Provider Database. Local Initiative shall maintain a centralized database which contains data regarding Plan Participating Providers. Such database shall serve as the controlling source of data concerning Plan Participating Providers for purposes of providing Health Care Services pursuant to the terms of this Agreement. Plan's and Local

Initiative's support of and access to the database shall be established in accordance with Local Initiative policies and procedures. Notwithstanding the foregoing, the Local Initiative policies and procedures shall include adequate provisions for Plan to: 1) have on-line user access to the Plan Participating Provider Database, 2) have report writing access to all respective Plan Participating Provider data contained in the centralized Plan Participating Provider Database on a real-time basis, and 3) receive transaction update records of all respective Plan Participating Provider data contained in the centralized Plan Participating Provider Database on a timely and routine basis as mutually agreed to by Local Initiative and Plan in the above referenced Local Initiative policy and procedures.

3.18 Additional Responsibilities. Local Initiative shall have additional responsibilities as determined by Local Initiative. The additional responsibilities shall be included in policies and procedures developed by Local Initiative after consultation with Plan.

ARTICLE IV.
PLAN RESPONSIBILITIES

4.01 Arrange Health Care Services. Plan shall provide or arrange for the provision of all Health Care Services, including, without limitation, Emergency Services and Urgent Care Services, to Plan Members as identified on the Eligibility List provided by Local Initiative pursuant to Section 3.06 herein. Plan shall also provide or arrange the provision of all Health Care Services and related functions as provided in the Delegation Agreement, incorporated by reference and attached hereto as Exhibit 8; provided that Local Initiative shall have the right to directly provide or arrange for the provision of Health Care Services in accordance with the provisions of Section 3.13 herein. In addition to the foregoing, Plan shall provide or arrange for the provision of all Supplemental Health Care Services, incorporated by reference and attached hereto as Exhibit 6, Attachment "B." Subject to the provisions of Section 4.11, herein, Plan agrees that it shall retain the responsibility for timely payment of all Emergency Services rendered by both Plan Participating Providers and non-contracting providers, and that Plan will not delegate the responsibility for payment of such claims to Plan Participating Providers or any other third party. In order to promote cost effective provision of Health Care Services to Medi-Cal Members, Local Initiative may arrange for specified Health Care Services to be made available to Plan Partners through a single source identified by Local Initiative. Plan may, at its option, use such single source to provide the specified Health Care Services to Plan Members at Plan's sole cost and expense. Plan's obligation to provide Health Care Services under this Agreement is limited to the Plan's Service Area and subject to Plan's capacity limitation, as specified in this Agreement.

4.02 Provider Network/Provider Contracts.

(a) Standards. All Health Care Services shall be provided by duly licensed, certified or accredited Plan Participating Providers who will provide such services consistent with the scope of their license, certification or accreditation and in accordance with the standards of medical practice in the community. In addition, Plan Participating Providers shall satisfy the

standards for participation and all applicable requirements for providers of health services under the Medi-Cal Agreement and the Medi-Cal program as set forth in Title 22 of the California Code of Regulations, Article 4, Section 51200 *et seq.* and any additional standards and criteria promulgated by Local Initiative from time to time, including any confidentiality standards related to services. Plan Participating Provider facilities shall comply with the facility standards established by DHCS as set forth in Title 22, California Code of Regulations, unless specifically waived by Local Initiative and DHCS. Plan and such facilities shall cooperate with inspections of such facilities, as conducted by DHCS, the Department of Health and Human Services ("DHHS"), or Local Initiative staff, that are required to assess compliance with DHCS facility standards including the submission of the results of pre-operational and expansion site reviews, in the manner and time required by the Medi-Cal Agreement. All laboratories used to perform Health Care Services for Plan Members shall comply with all federal and state laws and regulations and the requirements of the Medi-Cal Agreement and the DDA. All Plan Participating Providers and facilities shall be subject to written approval by Local Initiative and DHCS prior to their provision of Health Care Services to any Plan Member.

(b) Credentialing. Plan shall perform and/or may delegate all activities related to credentialing and re-credentialing Plan Participating Providers in accordance with Plan's credentialing criteria, the NCQA Delegation Agreement (Exhibit 10) and the standards of DHCS, DMHC, NCQA and Local Initiative. As part of its credentialing and re-credentialing process, Plan shall cooperate with any facility or primary care services site review procedure implemented by Local Initiative or DHCS. Except as otherwise set forth herein, Local Initiative shall be responsible for the cost of any facility or primary care services site review which is performed exclusively by Local Initiative. Except as set forth in Section 4.02(f) below, all Plan Participating Providers shall meet Plan's commonly applied credentialing criteria. Local Initiative shall monitor Plan's credentialing and re-credentialing activities to ensure its effectiveness, completeness and compliance with applicable standards.

(c) Provider Contracts.

i. Plan shall prepare written standard form Plan Subcontracts for the purposes of contracting with Plan Participating Providers to provide Health Care Services to Plan Members. Such Plan Subcontracts may be form amendments to Plan's standard Medi-Cal provider contracts. The Plan Subcontracts shall obligate Plan Participating Providers to comply with the terms and conditions of this Agreement, and shall be in compliance with all the requirements of the Medi-Cal Agreement, the DDA, the Knox-Keene Act, and all applicable state and federal laws and regulations, and shall include any standard provisions as required by DMHC or DHCS. The form Plan Subcontracts, and any proposed amendments thereto, shall address each of the provisions set forth in Exhibit 3 hereto. Form Plan Subcontracts and any proposed amendments thereto shall be submitted to Local Initiative for its review and approval solely for the purpose of determining whether such Plan Subcontracts comply with the requirements of this Section 4.02(c). In the event Local Initiative does not expressly disapprove any form Plan Subcontract within forty five (45) calendar days of receipt, said form Plan Subcontract shall be deemed approved by Local Initiative. Notwithstanding the foregoing, upon notice to Plan, Local Initiative retains the right to subsequently disapprove any form Plan

Subcontract due to a change in law or regulation. No Plan Subcontract or amendment thereto shall become effective until any required DHCS or DMHC approvals have been obtained. In the event Plan fails to submit for approval any Plan Subcontract at Local Initiative's request, Plan shall be subject to sanctions in accordance with Article 5 and Exhibit 5, herein. Notwithstanding the foregoing, in the event Local Initiative directly provides or arranges for the provision of Health Care Services, as defined in Section 3.13 herein, Local Initiative agrees it will not use any Proprietary Information of Plan (as defined herein) for Local Initiative's own commercial benefit.

ii. Plan shall maintain and make available to DMHC, DHCS and Local Initiative copies of all executed Plan Subcontracts.

iii. In accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated thereunder by the DHCSS and other applicable laws as may be promulgated and amended from time to time ("HIPAA"), in order to protect Protected Health Information, Plan shall enter into with its Plan Participating Providers which are Business Associates, a business associate agreement in the form attached hereto at Exhibit 8 or another equivalent form approved by Local Initiative. The business associate agreement between Plan and Plan Participating Provider shall be subject to the same review and approval by Local Initiative as any Plan Subcontract referenced in Section 4.02(c)(i), herein.

(d) Adequacy and Availability. Plan shall demonstrate the continuous availability and accessibility of adequate numbers of Plan Participating Providers to provide Health Care Services to Plan Members on a 24-hour basis, seven (7) days a week, including the provision of Emergency Services. Plan will, at a minimum, meet the availability and accessibility standards as required by the Medi-Cal Agreement. Plan shall require its Plan Participating Providers, in accordance with this Section 4.02(d) and Exhibit 3 herein, to comply with Local Initiative's policies, procedures and performance standards regarding the referral of Plan Members to specialty care providers, to the extent such Local Initiative policies, procedures and performance standards are applicable to Plan. The determination of whether such Local Initiative policies, procedures and performance standards are applicable to Plan, shall be made by Local Initiative in its sole reasonable discretion. Plan Participating Physicians shall have appropriate coverage and referral arrangements for after-hours care, hospital care in the event the Plan Participating Physician does not have hospital medical staff privileges and services outside the Plan Participating Physician's scope of expertise. In order to demonstrate the aforementioned availability of Plan Participating Providers, on an annual basis, Plan shall conduct a provider access assessment as provided in Local Initiative performance standards and policies and procedures pursuant to Sec. 10.06.

Plan and Local Initiative agree that in order for Plan Members to have accessibility to adequate numbers of Plan Participating Providers, Plan Participating Providers shall include provider affiliated with the California Children's Services ("CCS") program. Specific provisions of the aforementioned CCS contracting requirement shall be delineated in Local Initiative performance standards and policies and procedures as provided in Section 10.06 herein.

If Local Initiative determines that the Plan Participating Providers do not provide sufficient and accessible services for Plan Members, which determination may be made on a regional or ZIP code basis, Local Initiative shall promptly notify Plan of such deficiency, specifying in detail the basis for its findings. Plan shall thereafter have a reasonable opportunity to correct such deficiency by selecting additional or substitute Plan Participating Providers and establishing Plan Subcontracts with such selected providers. If Plan fails to take the required corrective action within a reasonable time period, Local Initiative may take appropriate corrective action or apply an appropriate sanction as provided in Local Initiative performance standards, policies and procedures and/or Exhibit 5 herein, including without limitation freezing assignment of additional Medi-Cal Members with Plan or contracting directly with the necessary providers as provided in this Agreement or withholding a portion of Plan's capitation payments.

(e) Changes in Provider Network. Plan will provide Local Initiative updates of Plan Participating Providers on a monthly basis, including credentialing information, and shall publish either a new list or amendments to an existing list no less than on a quarterly basis. Such information shall be provided in an electronic data transmission format acceptable to Local Initiative. In the event of termination of a Plan Participating Provider for any reason, Plan remains responsible for the continued provision of Health Care Services, to all Plan Members, including those who are receiving Health Care Services from the terminated Plan Participating Provider. Plan acknowledges and understands that all new Plan Participating Providers are subject to the approval of DHCS and Local Initiative.

(f) Traditional and Safety Net Providers/Disproportionate Share Hospitals.

i. Plan shall cooperate with and assist Local Initiative in complying with all Medi-Cal laws, regulations and Medi-Cal Agreement requirements regarding inclusion of Traditional and Safety Net Providers and Disproportionate Share Hospitals, including, without limitation, providing for reasonable participation of such providers as Plan Participating Providers, as determined from time to time by Local Initiative and approved by DHCS. In furtherance of the foregoing, Plan shall negotiate in good faith and use its best efforts to contract with any Traditional Provider or Safety Net Provider in Plan's Service Area that requests to contract with Plan and that meets Plan's commonly-applied credentialing criteria. Such contracts shall be upon Plan's standard terms and conditions for similarly licensed Plan Participating Providers, provided that rates of compensation must be reasonable and must comply with the requirements referenced in Section 4.02(f)(ii) herein. With respect to FQHCs specifically, Plan shall offer to contract with any FQHC in Plan's Service Area on the same terms and conditions offered to other Plan Participating Providers providing a similar scope of service, except that the reimbursement provisions of such contract shall comply with the reimbursement requirements referenced in Sections 4.02(f)(ii) and (iii) herein. With approval of the Local Initiative Board of Governors, Plan also may contract, and Local Initiative may request Plan to contract, with Traditional Providers and Safety Net Providers that do not meet Plan's commonly applied credentialing criteria in order to provide for reasonable participation of such Providers; provided that, any such Provider who does not meet Plan's commonly-applied credentialing criteria, at Plan or Local Initiative's option, may be required to participate in Local Initiative

designed or approved educational programs prior to providing Health Care Services to Plan Members.

In the event Plan does not contract with a Traditional Provider or Safety Net Provider who requests participation with Plan, including without limitation because such Provider does not meet Plan's commonly applied credentialing criteria or such Provider, in Plan's opinion, does not fit the definition of Traditional Provider or Safety Net Provider, Plan shall notify Local Initiative and provide Local Initiative with the reasons therefore for Local Initiative's review. In addition, any Provider which requests a contract with Plan on the grounds that the Provider is a Traditional Provider or Safety Net Provider, but which does not receive such contract shall have the right to seek review of the Plan's determination by Local Initiative. Plan shall cooperate with any such review by Local Initiative. Failure of Plan to negotiate in good faith with a Traditional Provider or Safety Net Provider is grounds for imposing sanctions upon Plan in accordance with, and subject to all reviews and appeals provided in, the Local Initiative sanctions policies and procedures. In the event Plan and other Plan Partners do not contract with a sufficient number of Traditional Providers and Safety Net Providers, Local Initiative shall have the right to directly contract with such Providers as provided in Section 3.13 herein.

ii. Plan contracting with and reimbursement to Traditional Providers and Safety Net Providers, including without limitation, FQHCs, Indian Health Service facilities, Rural Health Centers and Community Clinics, shall comply with all federal and state laws and regulations and Medi-Cal Agreement requirements.

iii. Without limiting the generality of Section 4.02(f)(ii) herein, with respect to FQHC's any contract between Plan and an FQHC shall provide (unless the FQHC agrees otherwise) that

(A) if a fee-for-service contract, Plan shall reimburse FQHC in a manner that is not less than the level and amount of payment made to other Plan Participating Providers for the same scope of services. FQHC may seek supplemental reimbursement from DHCS under the fee-for service contract; or

(B) if a capitated contract, FQHC shall accept capitation paid by Plan as payment in full for services provided to Plan Members under the contract. FQHC shall not seek supplemental reimbursement from Plan or DHCS for Health Care Services provided to Plan Members under the capitated contract.

Such reimbursement rates shall be subject to approval by DHCS and conditioned upon the FQHC's compliance with the record-keeping requirements imposed upon it by the applicable Medi-Cal laws and regulations. In the event a Plan Member is eligible to and does receive Health Care Services at an FQHC with which Plan does not contract, Plan shall pay the FQHC for such Health Care Services as required pursuant to the applicable federal and state laws and regulations and the Medi-Cal Agreement. L.A. Care and DHCS shall approve all contracts between FQHC's and Plan in order to comply with California Welfare & Institutions Code Section 14087.325.

(g) Discipline and Termination of Plan Providers. Local Initiative reserves the right to require Plan to suspend assignment of new enrollees to any Plan Participating Provider, to transfer Plan Members from any Plan Participating Provider, or to terminate a Plan Participating Provider from Local Initiative Medi-Cal Plan at any time. Plan shall develop, implement and maintain policies and procedures governing disciplinary actions and Plan Participating Provider appeals thereof, and governing Plan Participating Providers' appeals of actions taken pursuant to the first sentence of this Section 4.02(g), in accordance with applicable law and regulation and the Medi-Cal Agreement. Such policies and procedures shall be subject to approval by Local Initiative. Local Initiative reserves the right to coordinate, consolidate, and participate in any Plan Participating Provider disciplinary hearing conducted by Plan, including but not limited to, any hearing conducted in accordance with California Business and Professions Code Section 805, in accordance with Local Initiative's policies and procedures as adopted pursuant to Sections 10.05 and 10.06, herein, to the extent permitted by law. Plan shall promptly notify Local Initiative Quality Management Department of any disciplinary action taken by Plan or a Plan Participating hospital or medical group (upon Plan's receipt of notice of such action) against any Plan Participating Provider. Plan shall be responsible for notifying affected Plan Members in the event of termination of a Plan Participating Provider in accordance with all applicable laws and regulations, and for arranging for appropriate alternative Plan Participating Providers following the termination.

(h) Coordination of Auditing Activities. As provided in Local Initiative performance standards, policies and procedures, and Coordination of Financial Monitoring Attestation Letter, Local Initiative and Plan agree to coordinate the conduct of and share results of certain audits of Plan Participating Provider activities. Plan understands and agrees that neither the Plan Partner conducting the audit nor the Local Initiative acts as guarantors of the accuracy of any such audit results and that Plan should rely on its own independent judgment regarding such audit results. Plan shall use best efforts to ensure that any related Plan Participating Provider consent or authorization provision(s), as provided in Exhibit 3 herein, shall be included in all Plan Subcontracts.

(i) Minimum Financial Solvency Standards. Plan agrees that it shall, and shall require any Plan Participating Provider which is a Risk Bearing Organization maintain the following minimum financial solvency standards throughout the term of this Agreement:

(A.) Maintain, at all times, a positive working capital (current assets net of related party receivables, less current liabilities); and

(B.) Except for Plan Participating Providers which are hospitals, maintain, at all times, a minimum tangible net equity in accordance with Title 28, California Code of Regulations, Section 1300.76.

(j) Shared Monitoring of Plan Participating Providers: Pursuant to Local Initiative policy and procedure and in order to assist Plan in its oversight responsibilities regarding Plan Participating Providers, Local Initiative, in its sole discretion, may conduct a review and audit of one or more Plan Participating Provider functions and responsibilities in the following

operational areas: 1) credentialing: 2) cultural and linguistics monitoring; 3) health education monitoring; 4) primary care training requirements; and 5) utilization management. The audit results and reports obtained and developed by Local Initiative shall be made available to Plan. Plan may utilize any such audit reports and results, if Plan so elects, to assist Plan in fulfilling Plan duties and obligations under this Agreement, the Medi-Cal Agreement, Local Initiative policies and procedures, Local Initiative performance standards, and law and regulation.

4.03 Acceptance of Members and Limitations on Enrollment. Plan shall maintain, (i) sufficient Plan Participating Provider capacity in Plan's Service Area, and (ii) all required DMHC approvals therefore, to enable Plan to accept enrollment with Plan of Medi-Cal Members in mandatory aid codes up to Plan's Maximum Enrollment Target as set forth on Exhibit 2. Plan shall accept as Plan Members all Medi-Cal Members who choose Plan and a Plan Participating Physician as his or her Primary Care Physician and Plan shall accept and receive additional Medi-Cal Members in Plan's Service Area who either do not designate a Plan or Plan Participating Provider and who are assigned by Local Initiative to Plan, up to Plan's Maximum Enrollment Target set forth on Exhibit 2. If Plan is unable to accept additional membership in excess of the Plan's Maximum Enrollment Target under the Local Initiative Medi-Cal Plan, Plan shall provide Local Initiative at least sixty (60) calendar days advance written notice and shall not be required to accept assignment of additional Medi-Cal Members following expiration of the sixty (60) calendar day notice period.

4.04 Protection of Members. Plan may not impose any limitations on the acceptance of Plan Members for care or treatment that it does not impose on other Plan Members or other enrollees or patients. Neither Local Initiative, Plan nor any Participating Provider may request, demand, require or seek directly or indirectly the transfer, discharge, or removal of any Plan Member for reasons of the Plan Member's need for, or utilization of, Health Care Services. Plan and Plan Participating Providers shall not discriminate against Plan Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000(d), rules and regulations promulgated pursuant thereto or as otherwise provided by law, regulation or the Medi-Cal Agreement. Plan and Participating Plan Providers will take affirmative action to ensure that Plan Members are provided Health Care services without regard to race, color, creed, religion, sex, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap, unless medically indicated.

4.05 Member Rights and Responsibilities. Plan shall develop, implement and maintain written policies that address Plan Members Rights and Responsibilities in accordance with all Local Initiative, Medi-Cal Agreement, NCQA Standards and other DHCS or DMHC requirements, and shall communicate such policies to Plan Members, Plan Participating Providers and Plan staff in accordance with Title 28, California Code of Regulations, Section 1300.68. Nothing in this Agreement shall be construed to limit Plan's right to recommend to DHCS disenrollment of any Plan Member for good cause as permitted by law.

4.06 Member and Plan Participating Provider Grievances. Plan shall implement and maintain a grievance system for the review of Plan Member and Plan Participating Provider grievances

which shall be in accordance with Section 3.09 and comply with the requirements of Local Initiative, DMHC and DHCS, including but not limited to CCR, Title 28, Section 1300.71.38, as this regulation applies to Provider grievances.

4.07 Community Health and Excluded Service Linkages. Plan shall develop, implement and coordinate all required referral and linkage systems for mental, health, dental, California Children Services, family planning, Indian health services, Department of Public Health services, FQHC services and any other community health or excluded services, including in-home care, skilled nursing, AIDS and senior services, in accordance with the requirements of the Medi-Cal Agreement. In conjunction with California Children Services, as provided in the Medi-Cal Agreement, Plan shall implement policies and procedures, referral activities, and provide Health Care Services prior to and after referral as appropriate. Plan's child health and disability prevention (CHDP) system for Plan Members shall be operated in accordance with Title 17, California Code of Regulations, Section 6800, *et seq*. Plan shall provide medical case management services and coordination in accordance with the Medi-Cal Agreement. Plan shall provide all Health Care Services related to dental services in accordance with the Medi-Cal Agreement. Plan community health and excluded service linkage systems shall ensure appropriate coordination and continuity of care between the Plan Member's Primary Care Physician and the local health departments or other agencies or providers to which the Plan Member may be referred. Plan shall enter into and maintain during the term of this Agreement Memoranda of Understanding (MOU) with local health departments and such other agencies as are required pursuant to the Medi-Cal Agreement. Such MOU shall be incorporated herein by reference. Local Initiative shall assist Plan in coordinating execution and implementation of such MOU. Plan shall monitor these activities and shall provide Local Initiative with periodic reports regarding these activities as requested by Local Initiative.

4.08 Quality Management Program. Plan shall maintain and implement a quality management program to review the quality of Health Care Services provided to Plan Members in accordance with the requirements of and subject to the approval of DMHC and DHCS. Plan's quality management program, with respect to review of Health Care Services provided to Plan Members, shall be consistent with and incorporate and implement the requirements of the Local Initiative quality management program. Plan's quality management program shall be subject to Local Initiative's approval solely with respect to determining whether the program is in compliance with the requirements of the Local Initiative quality management program. Plan shall maintain a separate quality management committee for reviewing matters related to Plan Members which shall meet at least quarterly. Plan may satisfy this requirement by establishing a subcommittee to the existing Plan quality management committee. Plan shall, through such Plan quality management committee or subcommittee, perform quality management reviews of Health Care Services provided to Plan Members as brought before Plan internally or from Local Initiative's Medi-Cal Plan quality management committee, the DMHC, DHCS and any other governmental agencies with regulatory or enforcement jurisdiction over this Agreement. Plan grievance and utilization management actions shall be incorporated into Plan's quality management activities. The Plan quality management committee shall keep minutes of the committee meetings which, to the extent such minutes pertain to Health Care Services provided to Medi-Cal Members, shall be made available for review at Plan by Local Initiative quality

management department or quality management committee members or staff. A Local Initiative designated physician shall participate in the Plan quality management committee's review of Plan Member matters. As more fully set forth in Section 3.08, it is specifically understood and agreed that the conduct of activities described hereunder will at all times comply with any laws relating to the confidentiality of medical information and will preserve all privileges as set forth in California Health and Safety Code Section 1370. Plan shall also maintain and implement a disease management program in conjunction with the Health Care Services provided to Plan Members. The disease management program shall be in accordance with the policies and procedures and the performance standards as provided in Section 10.06 herein.

4.09 Utilization Management. Plan shall develop a utilization management program in conformance with the requirements of DMHC, DHCS and the Local Initiative utilization management program. Plan's utilization management program shall include, without limitation, mechanisms for monitoring and oversight of any utilization management activities delegated to Plan Participating Providers. Plan shall maintain a utilization management committee which shall meet as frequently as necessary. The Plan utilization management committee shall keep minutes of the committee meetings, copies of which shall be made available to Local Initiative to the extent such minutes pertain to Health Care Services provided to Medi-Cal Members. In the conduct of such activities, information and reports relating to Plan Members access, and the quality of care rendered to them shall, from time to time, be provided by Plan to Local Initiative. It is specifically understood and agreed that the conduct of the activities described hereunder will at all times comply with any and all laws relating to the confidentiality of medical information and will preserve all privileges as set forth in California Health and Safety Code Section 1370.

4.10 Management Information System.

a) Maintenance and Management**.** Plan shall develop, implement and maintain a management information system that will provide support for all of Plan's processes and procedures related to the flow and use of data within Plan. The Plan management information system must enable Plan to meet all requirements of this Agreement and the Medi-Cal Agreement, and shall be compatible with the Local Initiative management information system and enable Plan to provide and receive data in the electronic format and on the media specified by Local Initiative. Plan's management information system will, at a minimum, provide: (i) all Medi-Cal eligibility data; (ii) data regarding Members enrolled with Plan; (iii) Plan's claims status and payment data; (iv) encounter-level Health Care Services delivery data; (v) Plan and Plan Participating Providers network information; (vi) pharmacy and formulary medication and claims data; and (vii) all financial, encounter and other data as is required to be maintained pursuant to the Medi-Cal Agreement. Local Initiative shall work with Plan in good faith to minimize interface problems between Plan and Local Initiative management information systems.

b) Health Information Technology

1. Local Initiative and Plan shall use their best efforts to coordinate and cooperate regarding any law, regulation or executive order pertaining to health information technology. This coordination and cooperation may consist of, but is not limited to, exchanging electronic health information in accordance with Local Initiative performance standards and technical bulletins.

2. Notwithstanding the above, Plan shall complete those actions necessary to support a Plan Participating Provider's ability to pharmacy e-prescribe by providing appropriate access to Plan Member eligibility and medication history, and formulary information in compliance with prevailing industry standards and applicable law, regulation or executive order, and in accordance with Local Initiative policy and procedure, however, in no event shall Plan be required to complete any actions, set forth above, prior to June 30, 2010. Plan shall be responsible for funding pharmacy e-prescribing costs as provided in this Section 4.10(b)(2) in an amount not to exceed $100,000 annually (measured by each twelve month period of the term of this Agreement) during the term of this Agreement.

4.11 Claims.

(a) Claims for Health Care Services. Plan, and as applicable, Plan Participating Provider, shall pay uncontested claims for Emergency Services or other Health Care Services for which a bill has been generated for a Plan Member within the shorter of the time specified in the applicable Plan Subcontract, the time specified in the Medi-Cal Agreement or applicable laws and regulations. Including but not limited to paying all claims in the time and manner prescribed by CCR, Title 28, 1300.71(e).

(b) Contested Claims. If the claim is contested by Plan, or Plan Participating Provider, the appropriate party shall notify the Plan Member that the claim is contested within the time period specified in this Section 4.11 or within the time specified by law and shall provide Local Initiative a copy of the notice, upon request. The notice shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. Local Initiative, at its option, may or as provided by policy and procedure) monitor the claim resolution process and facilitate the resolution of any such Plan Member claim disputes.

(c) Claims Processing. Plan, and as applicable, Plan Participating Provider, shall have sufficient claims processing payments systems, administrative capability and financial solvency to timely process and pay any provider claims, reasonably determine the status of received claims and calculate and reserve sufficient amounts for "Incurred But Not Reported" claims. Plan agrees to operate its claims processing system in a manner that assures that providers of authorized Health Care Services, including Plan Participating Providers and non-contracting providers, receive timely payment for Health Care Services rendered to Plan Members. For purposes of this Agreement, timely payment shall mean payment within the shorter of the time specified in the applicable Plan Subcontract, the time specified in the Medi-Cal Agreement or applicable laws and regulations.

(d) Prohibition Against Delegation of Claims Payment Function. Notwithstanding the foregoing**,** effective January 1, 2003, Plan agrees that it shall rescind any prior delegations and no longer delegate the claims payment function for any Emergency Services to any Plan Participating Provider unless Plan has submitted appropriate notice, pursuant to Local Initiative's policies and procedures, no less than thirty (30) calendar days prior to such delegation documenting:1) Plan's successful efforts to conduct due diligence in determining Plan Participating Provider's compliance with Local Initiative's policies and procedures, and, 2) Plan's affirmative assertion that Plan Participating Provider is in substantial compliance with such policies and procedures. During the thirty (30) calendar day notice period, Local Initiative, in its sole discretion, shall have the right to prohibit delegation to the Plan Participating Provider upon providing Plan with written notice. Local Initiative shall have the authority, in Local Initiative's reasonable sole discretion, to require Plan to rescind delegation to any Plan Participating Provider upon no less than forty-five (45) calendar days' prior written notice to Plan; however Local Initiative may require rescission, effective immediately upon Plan's receipt of such notice, in the case of exigent circumstances that pose an immediate threat to Plan Members' health or access to Health Care Services. Plan shall take appropriate actions to assure that Plan Participating Providers pay any such delegated claims in accordance with Section 4.11(b) and this Section 4.11(c), herein. The parties agree that any delegations prior to the execution of this Agreement where delegate remains in good standing are not required to be rescinded pursuant to this Section (d).

(e) Plan Receipt of Emergency Services Claims. Notwithstanding the foregoing, Plan shall take appropriate actions, as required by Local Initiative policies and procedures, to assure that Plan is the original recipient of all Emergency Services claims. In the event such Emergency Services claims are delegated, Plan shall, in turn, forward such Emergency Services claims to the responsible Plan Participating Provider within ten (10) calendar days of Plan’s receipt of such claims.

(f) References. Any references to Emergency Services in this Section 4.11 are applicable only to those Emergency Services that are not part of an inpatient stay.

(g) Offset. In the event Plan, or Plan Participating Provider, fails to timely process and pay any claim(s) as provided in this Section 4.11, Local Initiative may, in its reasonable sole discretion, upon ten (10) days written notice, process and pay such claim(s) on Plan's or Plan Participating Provider’s, behalf and, thereupon, offset any payment amount(s) (including Local Initiative's reasonable out-of-pocket costs) otherwise due and owing to Plan as provided in Section 6.01(a), herein or any policy and procedure initiated pursuant to this Agreement. In its written notice, Local Initiative shall provide to Plan the reasons for and amount of any such offset. Any such payment and offset shall be made by Local Initiative in accordance with Local Initiative's policy and procedures, including provisions for any Plan appeal regarding Local Initiative's payment and offset.

4.12 Reimbursement Services and Reports; Encounter Data.

In accordance with the provisions of the Plan Subcontracts, Plan shall provide all normal reimbursement services, including those relating to the payment of capitation, processing and payment of any claims on a Medi-Cal fee-for-service basis, administration of any stop-loss, and risk sharing programs, and any other payment mechanism set forth in the various Plan Subcontracts. Plan shall make no payment to any Plan Participating Provider, directly or indirectly, which will act as an inducement to reduce or limit Medically Necessary Health Care services and shall comply with any stop-loss protection and disclosure requirements of 42 CFR 417.479. and the Medi-Cal Agreement regarding any physician incentive plans.

(b) Upon request, Plan shall provide, and shall require any Plan Participating Provider which is a Risk Bearing Organization to provide, copies of any and all records which reflect Plan and/or Plan Participating Provider financial status or solvency as well as Plan's and Plan Participating Partner's compliance with regulatory and contractual requirements relating to the timely processing and payment of claims, including but not limited to, the following:

1) payment records, summaries and reconciliations, and payment compensation reports which Plan customarily provides to its Plan Participating Providers and as specified in Title 22, California Code of Regulations, Sections 538(c)(4), (5) and the Knox Keene Act;

2) quarterly and audited annual financial statements; general ledger or trial balance, bank statements and bank reconciliations; detail accounts receivable aging reports; the methodology and calculation of allowance for doubtful accounts; cash receipt reports; copies of deposit slips and copies of checks received (including check stubs);

3) shared risk pool schedules and related supporting documents; quarterly shared risk pool reconciliation reports;

4) detail accounts payable aging reports; check registers; vendor invoices and copies of cancelled checks; schedules of accrued expenses and other liabilities;

5) incurred but not reported ("IBNR") methodology(s); IBNR calculation & reconciliation reports;

6) list of all related party transactions; loan agreements; amortization schedules of loans; lists of all the fixed assets with current year additions and disposals; supporting documents of income tax provisions; equity section rollover statements; monthly enrollment data used in IBNR calculations; monthly claims payments reports;

7) copies of reinsurance (stop loss) policies; copies of malpractice and error & omission insurance policies; copies of all other insurance policies; detail organizational & affiliation charts; company accounting & financial policies & procedures; company claims processing policies & procedures; health plan risk pool methodology(s); provider risk pool methodology(s); contract and lease agreements;

8) detail capitation disbursement reports; provider oversight assessments of financial viability and claims processing; any other documentation that supports any balance in the financial statements;

9) all documentation that supports the verification of timely and appropriate payment/processing of provider claims, including but not limited to: (a) claim reports; claim information – claim number, member name, physician name, ER, non ER, family planning, contracted, non-contracted, date of service, date of receipt, amount billed, amount paid, CPT code, date paid, pended, or denied, check (payment) number and check (payment date; and (b) all documentation necessary to determine adjudication, provider notification, and payment status of the selected claims (claim forms, EOB/remittance advice, medical records, fee schedule, bank statements, notice to defer, deny, or modify, etc).

Upon Local Initiative's prior consent, Plan may provide summaries of such information in a format acceptable to Local Initiative.

(c) Plan and upon request of Local Initiative, any Plan Participating Provider, shall provide to Local Initiative encounter data for services provided to Medi-Cal Members, in an electronic data transmission format, as required by Local Initiative policies, procedures and performance standards, as necessary to enable Local Initiative to comply with DHS, DMHC and Local Initiative requirements. Such data shall include, but not be limited to, laboratory, claims, vision, California Health and Disability Prevention Program ("CHDP"), radiology and pharmacy data. Such data shall be provided within such time frames as may be necessary to enable Local Initiative to comply with DHS and DMHC submission requirements or as otherwise reasonably requested by Local Initiative. In the event any Plan Participating Provider provides data directly to Local Initiative, Local Initiative shall provide that data to Plan. Plan shall implement policies and procedures for ensuring the complete, accurate, and timely submission of data for all Health Care Services for which Plan has provided, arranged for the provision of, or incurred any financial liability, whether directly or through Plan Participating Providers or other arrangements. Plan and/or Plan Participating Provider shall provide Local Initiative, in the frequency, format, and manner specified by DHS, and/or Local Initiative with data for each Plan Member visit to FQHCs and Rural Health Centers contracted with the Plan within thirty (30) days of such request, in accordance with the Medi-Cal Agreement. In addition, upon request by Local Initiative, Plan and/or Plan Participating Provider shall report to Local Initiative, hospital inpatient days pursuant to California Welfare and Institutions Code §14105.985(b)(2), as well as report required information pertaining to Plan's and/or Plan Participating Provider's administration of the Disproportionate Share Hospital program within thirty (30) days of such request. Plan and/or Plan Participating Provider shall comply with Local Initiative's policies and procedures pertaining to data reporting performance incentive requirements. Local Initiative shall adopt policies and procedures which allow for the retention of some portion of each capitation payment to Plan as provided for in Section 6.01 herein, in order to ensure Plan's achievement of the data reporting performance incentive standards as delineated in the Medi-Cal Agreement.

4.13 Manuals; Member Materials; Membership Cards/Information. Plan shall have sole responsibility to notify its Plan Participating Providers, through amendments to provider manuals

or as otherwise deemed appropriate by Plan, of the specific duties and obligations of Plan Participating Providers under this Agreement and the Local Initiative Medi-Cal Plan, including without limitation, the reporting and other requirements of the Knox-Keene Act, the Medi-Cal Agreement, and this Agreement and the performance standards and policies and procedures of Local Initiative, all as amended from time to time. Plan shall provide its Plan Participating Providers with Medi-Cal eligibility redetermination dates of the Plan Members assigned to those Plan Participating Providers.

(b) Within seven (7) calendar days after receipt of notice from Local Initiative of the effective date of enrollment with Plan, Plan shall distribute to new Plan Members an identification card, which identifies the individual as a Local Initiative Medi-Cal Plan Member and authorizes the provision of Health Care Services. Within such seven (7) calendar day period, Plan also shall distribute to such new Plan Member the information required to be provided to Members under applicable state laws and regulations, including without limitation, the Plan's Local Initiative evidence of coverage, provider directory and grievance procedures. Use of such materials shall be subject to the prior written approval of Local Initiative. Upon written notice to Plan, Local Initiative may, at its option, take responsibility for distribution of such materials to new Plan Members, provided that Plan shall maintain responsibility for providing such materials to Local Initiative for distribution and for the cost of postage. All such materials shall be subject to any required prior approval by DHCS or DMHC.

(c) Except as otherwise set forth herein, Plan shall have sole responsibility for the development, printing, and distribution of all Disclosure Forms, Evidences of Coverage and any other forms or materials which DMHC or DHCS requires to be distributed to Plan Members (collectively, "member materials"). All such member materials to be distributed to Plan Members, without exception shall be subject to the prior written approval of Local Initiative and shall include those items required by the Medi-Cal Agreement and/or Local Initiative policy and procedure or performance standards. Local Initiative shall have the right to use Plan’s trade name and trademark in all Local Initiative marketing, enrollment and other materials in order to identify Plan as a Plan Partner of Local Initiative. Plan shall include in its Member Materials distributed to Plan Members all Local Initiative affiliation statements and logos as, from time to time, may be required by Local Initiative. At Local Initiative's request, Plan shall work with Local Initiative and other Plan Partners to develop member materials which are uniform as to form and/or content to ensure consistency of presentation to all Medi-Cal Members. Plan shall use and distribute to Plan Members any uniform member materials or uniform provisions prepared by Local Initiative for inclusion with Plan's member materials which have been approved as to form and content by DHCS and DMHC and which DHCS, DMHC or Local Initiative requires to be uniform for all Medi-Cal Members. Uniform member materials shall be printed and distributed by Plan at Plan's sole cost and expense.

(d) Plan shall be required to obtain Local Initiative’s prior written approval of the content of materials which Plan distributes to its Medi-Cal Members and which, are not Member Materials (Non-Member Materials) as defined in Section 4.13(c) herein. Plan shall give Local Initiative thirty (30) calendar days prior written notice of intent to disseminate the Non- Member

Materials (along with a copy of the Non-Member Materials) in order to allow Local Initiative an opportunity to review the content of the materials. Local Initiative shall use its best efforts to review these materials and communicate its approval or disapproval of the Non- Member Materials to Plan within fourteen (14) calendar days of receipt of the Non- Member Materials. If Local Initiative does not communicate its approval or disapproval of the Non- Member Materials to Plan within thirty (30) calendar days, the Non- Member Materials shall be deemed approved. If Local Initiative disapproves such Non- Member Materials within that thirty (30) calendar days period, the parties shall meet and confer to resolve any outstanding issues and obtain any required regulatory approvals within the thirty (30) calendar days subsequent to the disapproval. In the event the parties are unable to reach agreement, Plan shall not be allowed to distribute the Non- Member Materials to Plan Members. Further, unless Local Initiative indicates otherwise, it is understood that Plan shall not be required to submit for approval any materials which text consists solely of verbatim paragraphs previously approved by Local Initiative (either alone or in an appropriate combination with other previously approved verbatim paragraphs).

(e) Upon reasonable request of Local Initiative and prior written consent of Plan, Local Initiative may use Plan-generated member education materials for distribution to Medi-Cal Members who are not Plan Members, at Local Initiative's sole cost and expense and subject to the terms and conditions set forth in the Generic Health Education Memorandum of Understanding.

(f) Local Initiative shall assume responsibility for the printing and distribution to Plan Members of any forms or other materials that are prepared by Local Initiative, but which are not member materials as referred to in Section 4.13(c), above, Local Initiative shall bear all related costs for the printing and distribution of such non-member materials to Plan Members.

(g) Local Initiative expressly reserves the right to directly correspond with, contact, or provide information and materials to, or receive information and materials from, any Plan Members, Plan Participating Providers, or Plan Participating Provider subcontractors with respect to operation of the Local Initiative Medi-Cal Plan, subject to Local Initiative having obtained any required DHCS or DMHC approval. Local Initiative shall provide Plan with a copy of any written correspondence, information or materials provided by Local Initiative to Plan Members, Plan Participating Providers or Plan Participating Provider subcontractors. Notwithstanding the fact that the parties acknowledge and agree that there is no prohibition regarding the providers which Local Initiative contracts with under the Medi-Cal program, it is not the intent of this Section 4.13(g) to provide a mechanism for Local Initiative to solicit provider contracts from Plan Participating Providers.

4.14 Pharmacy and Formulary Compliance. Unless provided or arranged directly by Local Initiative, Plan shall provide pharmaceutical services and prescribed drugs to Plan Members in accordance with all laws and regulations, including, without limitation, Title 22, California Code of Regulations, Section 53214, and in accordance with the requirements of the Medi-Cal Agreement and the DDA, as well as in accordance with any formulary which Local Initiative may adopt from time to time. Plan shall utilize any formulary in accordance with Local Initiative policies and procedures and/or performance standards. Plan's formulary shall be

expressly approved by Local Initiative. Plan shall also perform pharmaceutical utilization reviews to identify improvement opportunities, conduct appropriate intervention activities and prepare reports, as from time to time may be required by Local Initiative, including reports of outcomes for related improvement interventions for submission to Local Initiative at a frequency and in a manner as Local Initiative may mandate in Local Initiative policies and procedures and/or performance standards. Any modifications to the components of the formulary as described above shall be implemented pursuant to Sections 10.05 and 10.06, herein. Plan shall permit periodic audits upon reasonable notice by Local Initiative or DHCS to measure Plan's compliance with DHCS standards and to provide recommendations regarding improvement. Plan shall, by contract, require any Plan Participating Provider as well as any Plan Participating Provider subcontracted provider to provide Local Initiative with the same data and/or reports as required to be provided by Plan to Local Initiative under this Section 4.14.

4.15 Coordination of Benefits. Plan shall cost avoid and seek post-payment, as defined by the Medi-Cal Agreement, for the costs of Health Care Services rendered to a Plan Member to the extent a Plan Member is covered for such services under any other state or federal medical care program or under other contractual or legal entitlement, including but not limited to, private group or individual indemnification programs, in accordance with applicable coordination of benefits laws and regulations and the Medi-Cal Agreement. Plan shall comply with all policies and procedures adopted by the Local Initiative to implement the reporting requirements regarding cost avoidance and post payment recovery efforts as provided in the Medi-Cal Agreement.

4.16 Third Party Liability. Pursuant to the Medi-Cal Agreement, DHCS is responsible for follow-up and collection of third party liability payments where it has paid for related care. Accordingly, neither Plan nor Plan Participating Providers may attempt to recover costs of Health Care Services in circumstances involving casualty insurance, tort liability or workers' compensation or uninsured motorist coverage. And, neither Plan nor Plan Participating Providers may make a claim against the estate of any deceased Plan Member. Plan shall notify Local Initiative within ten (10) business days of Plan or a Plan Participating Provider discovering any circumstances involving a Plan Member which may result in the Plan Member recovering tort liability payments, casualty or other insurance payments or workers' compensation awards. Upon Local Initiative request, Plan shall also timely provide such additional information or records regarding such third party liability claims as may be required to be transmitted by Local Initiative to DHCS. Local Initiative, at its sole option, may also communicate directly with any Plan Participating Provider to facilitate such transmission of additional information and records to DHCS. If Local Initiative receives requested third party liability information directly from Plan Participating Provider, Local Initiative shall inform Plan of such receipt of information. This provision shall be deemed amended to allow Plan to pursue third party liens if and to the extent that the Medi-Cal Agreement is revised to permit such activity.

4.17 Plan Licensure and Compliance.

(a) Knox-Keene License. Throughout the term of this Agreement, Plan shall maintain licensure in good standing with the DMHC under the Knox-Keene Act.

(b) Regulatory Approval. Plan shall take all necessary steps to maintain throughout the term of this Agreement, via appropriate approval by all applicable regulatory bodies, including without limitation the DMHC, approval for Plan to participate in the Local Initiative Medi-Cal Plan and to provide Health Care Services under this Agreement within Plan's Service Area. Plan shall provide to Local Initiative written evidence of such approval prior to Local Initiative enrolling any Medi-Cal Members with Plan pursuant to this Agreement.

(c) Approved Service Area. Plan shall accept enrollment of Local Initiative Medi-Cal Plan Members under this Agreement only within the Plan Service Area.

(d) Licensure Changes/Limitations. Plan shall notify Local Initiative in writing within five (5) working days in the event of any suspension, restriction, or limitation placed on its license or approved Service Area by the DMHC.

(e) Compliance with Law. As more fully set forth in Section 10.20, Plan shall comply with all applicable federal and state laws and regulations, the DDA, the Medi-Cal Agreement and all requirements imposed on Plan by DHCS or DMHC directly or resulting from requirements imposed on Local Initiative.

(f) Local Initiative Performance Standards and Policies and Procedures. Subject to the provisions of Sections 10.05 and 10.06, Plan shall comply with all performance standards and policies and procedures as adopted or amended from time to time by Local Initiative.

(g) Plan Staff. All Plan employees working on matters relating to the Local Initiative Medi-Cal Plan or otherwise participating in Plan's performance of this Agreement shall be appropriately qualified and experienced in performance of such individual's duties and shall cooperate on a reasonable basis in all interactions between Local Initiative and Plan. Plan employees shall participate in Local Initiative in-service or other training programs as reasonably requested by Local Initiative. Plan, upon request of Local Initiative for any reason, may remove any Plan employee designated by Local Initiative from working on matters relating to the Local Initiative Medi-Cal Plan or to Plan's performance of this Agreement; provided that before such removal is effective, Local Initiative shall provide Plan with the reasons for the request and shall meet and confer with Plan with regard to such request and the impact such removal may have on Plan operations. If no agreement is reached regarding the removal of a Plan employee, either party shall be entitled to exercise any remedies available in the Agreement including, but not limited to, the imposition of sanctions as set forth in Exhibit 5 (Sanctions) except such remedies shall not include termination of the Agreement. However, no such sanction shall be imposed on Plan without the prior approval of the Chair of Local Initiative's Board of Governors or the Chair's designee, and the Local Initiative's Chief Executive Officer. This provision does not apply to Plan clinical personnel who provide Health Care Services to Plan Members or to Plan senior management-level staff.

4.18 Additional Support to Local Initiative. Plan shall use best efforts to provide additional support to the Local Initiative with regard to Local Initiative-sponsored community health programs, Local Initiative legislative and lobbying activities, Local Initiative-sponsored provider

training and development assistance programs, other Local Initiative-sponsored educational and training activities, and the operations and activities of the Public Advisory Committees as set forth in Section 3.12, herein or as reasonably requested by Local Initiative. Plan shall use its best efforts to provide Local Initiative with reasonable advance written notice prior to participating or undertaking any legislative or lobbying activities with regard to any matter concerning Local Initiative or the Local Initiative Medi-Cal Plan.

4.19 Nondiscrimination. Plan shall, and will use its best efforts to ensure that Plan Participating Providers shall not unlawfully discriminate, harass or allow harassment against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability (including HIV or AIDS), mental disability, medical condition (including cancer), marital status, age (over 40), sex, or denial of family care leave. Plan shall, and will use its best efforts to ensure that Plan Participating Providers shall insure that the evaluation and treatment of employees and applicants for employment are free of such discrimination and harassment. Plan and Plan Participating Providers shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0, *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Plan and Plan Participating Providers shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

4.20 Identification of Officers, Owners, Stockholders, Creditors. If applicable, Plan shall identify the names of the following persons by listing them on Exhibit 4 of this Agreement: (a) Plan officers and owners; (b) individuals or entities who own or control directly or indirectly, greater than ten percent (10%) of any Plan; and (c) major creditors holding more than five percent (5%) of any debts owed by Plan. Plan shall notify Local Initiative within thirty (30) calendar days of any changes in the information provided in Exhibit 4. Plan shall notify Local Inititative no less than sixty days (60) calendar days prior to any proposed restructuring, merger, sale of stock or other transaction that would result in change of ownership of greater than a forty percent (40%) interest in the Plan through either: (1) change in the ownership interest of the Plan itself; or (2) a change in the ownership interest of any entity or individual that possesses, directly or indirectly, sufficient power to direct or cause the direction of the restructuring, merger, sale of stock or other transaction that would result in a change of ownership of the Plan (whether through the ownership of voting securities, by contract or otherwise).

4.21 Fraud and Abuse Reporting. Plan shall report to the Local Initiative all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) State working days of the date when Plan first becomes aware of or is on notice of such activity. Plan shall establish policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of Health Care Services under the Medi-Cal program. Plan

shall notify DHCS and Local Initiative prior to conducting any investigations, based upon Plan's finding that there is reason to believe that an incident of fraud and/or abuse has occurred, and, upon the request of DHCS or Local Initiative, consult with DHCS and Local Initiative prior to conducting such investigations. Local Initiative shall have the option to participate in any such investigations. Plan shall participate in and require Plan Participating Provider to participate in any fraud investigation conducted by Local Initiative or a third party at the direction of Local Initiative. In conjunction with this Section 4.21, Plan and Plan Participating Provider shall share with Local Initiative any information, documents and other tangible evidence of any such fraud investigations. Plan shall report investigation results within ten (10) business days of conclusion of any fraud and/or abuse investigation.

4.22 Additional Responsibilities. Plan shall have additional responsibilities as shall be mutually agreed upon by Plan and Local Initiative and shall be included in policies and procedures that will be developed by Local Initiative, after consultation with Plan, during the term of this Agreement.

ARTICLE V
SANCTIONS

5.01 Sanctions. In the event Plan or its Plan Participating Providers fail to comply with the performance standards adopted or amended from time to time by Local Initiative or otherwise fail to comply with Local Initiative policies and procedures or DHCS or DMHC requirements, Local Initiative shall have the right to impose sanctions in accordance with Exhibit 5 hereto. The Local Initiative shall notify DHCS of any sanctions imposed by the Local Initiative upon Plan or Plan Participating Providers pursuant to this Agreement.

ARTICLE VI
COMPENSATION

6.01 Capitation Payments.

a) Payment Amounts.

i) In exchange for Health Care Services and Supplemental Health Care Services provided to and/or arranged or paid for on behalf of eligible Plan Members by Plan, Local Initiative agrees to pay Plan for each Plan Member, from the first day of eligibility, the Capitation Payment amounts specified in Exhibit 6. Capitation Payment amounts for certain aid groups will be computed to reflect the differences in the Plan's anticipated costs and utilization for Plan Members' Health Care Services as compared to those variables for the entire population of Local Initiative's Medi-Cal Members, as further described in Exhibit 6.

ii) Plan agrees to accept these amounts as payment in full for providing or arranging and paying for Health Care Services, except for any applicable co-payments or amounts recovered by Plan through Coordination of Benefits.

iii) Capitation Payments to Plan for each Plan Member on Plan's Eligibility List each month shall be paid by Local Initiative to Plan within ten (10) calendar days after Local Initiative's receipt of the Monthly DHCS Payment for such month, subject to any withholding or offset authorized pursuant to this Agreement, including but not limited to; 1) Local Initiative's action to recoup amounts paid by Local Initiative due to Plan's failure to make timely payment for Health Care Services hereunder; 2) Local Initiative's adjustment of Plan's Capitation Payment in the event Plan elects not to perform certain Health Care Services as provided in Section 6.01(b) and Exhibit 6, below; or 3) Local Initiative's imposition of sanctions pursuant to section 5.01. Any Capitation Payment amounts due hereunder but not paid by Local Initiative by the tenth (10th) business day after Local Initiative's receipt of the Monthly DHCS Payment, shall accrue interest until paid, at a fixed rate equal to one percent (1%) over the prime rate of interest charged by Bank of America or its successor as of the first day of the month in which the payment became overdue.

iv) In the event of any withhold or offset of any portion of the Monthly DHCS Payment other than a withhold or offset due to the acts or omissions of another Plan Partner, Capitation Payments to Plan hereunder shall not be due or payable by Local Initiative until such portion of the Monthly DHCS Payment is actually received by Local Initiative. In the event such DHCS withhold or offset is re-instated to Local Initiative, Local Initiative shall pay Plan any corresponding amounts withheld or offset within ten (10) calendar days of Local Initiative's receipt of payment from DHCS.

b) Adjustments. Capitation Payment amounts may be adjusted by Local Initiative:

i) to reflect implementation of state or federal laws or regulations, changes in the state budget or DHCS policy, changes in covered Health Care Services (including changes in DHCS withhold amounts related to Supplemental Health Care Services) or changes in capitation rates implemented by DHCS under the Medi-Cal Agreement that result in increases or decreases to the average capitation rates paid by DHCS to Local Initiative. Any such adjustment to the Capitation Payment may be retroactive. Local Initiative shall give Plan notice of the effective date of any Capitation Payment adjustment. Any such change in Capitation Payment amounts shall be deemed a mandated amendment subject to the provisions of Section 10.05(c) herein.

ii. to reflect any changes in the respective responsibility of Plan and Local Initiative in the event Local Initiative directly provides or arranges for the provision of Health Care Services as provided in Section 3.13 herein. Capitation Payment amounts shall be modified as actuarially determined by DHCS or, at Local Initiative's option, by an independent actuary with appropriate experience and expertise chosen by the Local Initiative Board of Governors. Local Initiative shall give Plan at least thirty (30) days' prior written notice of any change in Capitation Payment amounts pursuant to this Section 6.01(b)(ii). Such change in Capitation Payment amounts shall be deemed an amendment subject to the provisions of Section 10.05 herein.

iii. to reflect any amounts withheld or offset as a result of Local Initiative's imposition of sanctions pursuant to section 5.01, or Local Initiative's action to recoup amounts paid by Local Initiative due to Plan's failure to make timely payment for Health Care Services required hereunder.

iv. to reflect Local Initiative's approval of Plan's election not to accept from Local Initiative the delegation of certain components of the Health Care Services or other services required by this Agreement ("Other Services"). Local Initiative shall adjust Plan's Capitation Payment by the amount of Local Initiative's total cost (including overhead) to provide these same Health Care Services or Other Services. Plan shall receive a thirty (30) calendar day prior notice of such adjustment to the Capitation Payment, subject to section 10.05(c) herein. Notwithstanding the foregoing, Plan understands and agrees that nothing contained in this Section 6.01(b) shall relieve Plan of its obligation to maintain its license under the Knox-Keene Act, including meeting all requirements thereunder. Any such election by Plan and approval by Local Initiative shall be documented in an express writing between the parties.

(c) DHCS Payment. Notwithstanding anything to the contrary in this Agreement, Local Initiative's obligation to pay Plan any Capitation Payment amounts hereunder shall be subject to Local Initiative's receipt of funding therefore from DHCS and no such Capitation Payments shall be due and owing to Plan until Local Initiative's receipt of such funding.

6.02 Retroactive Adjustments. If DHCS determines that a Plan Member was improperly omitted from the Eligibility List for a period of time during which the Plan Member actually was eligible for Health Care Services, Local Initiative will pay Plan for that Member for such time period at the Capitation Payment rate specified in Exhibit 6 within ten (10) business days of receiving the corresponding payment from DHCS. Plan shall be responsible for the cost of any Health Care Services provided to such Plan Member during such time period. If DHCS determines that a Member was improperly enrolled or should have been disenrolled in a prior month, Plan may, with Local Initiative's prior approval, elect to remain liable for any Health Care Services provided and retain the Capitation Payment or forego the Capitation Payment, and liability for such Health Care Services shall revert to DHCS, in accordance with the Medi-Cal Agreement. Plan agrees that Local Initiative is not liable for any Capitation Payment amounts payable to or deductible from Plan's compensation amount due to any errors in the Eligibility List not caused by Local Initiative unless and except to the extent that DHCS has recognized and corrected such errors, informed Local Initiative of the correct information, and made appropriate payment adjustments under the Medi-Cal Agreement. Plan shall be responsible for the cost of Health Care Services rendered to Plan Members regardless of any delay in transmission of Eligibility Lists caused by DHCS. In the event of a delay in Eligibility List transmission caused by Local Initiative, Plan shall pay for any Health Care Services rendered between the effective date of enrollment of the Plan Member and the date Plan received notice of such enrollment, and Plan shall have the right to request reimbursement from Local Initiative for any such costs incurred by Plan. Local Initiative shall reimburse Plan for any such costs, at Plan's rates for Health Care Services provided by Plan Participating Providers, upon Plan's demonstration that the Eligibility List transmission delay was caused by Local Initiative and upon provision of evidence of the costs actually incurred by Plan. Such reimbursement by Local Initiative shall be

in addition to any Capitation Payment amount due to Plan for such Plan Member in accordance with Section 6.01 herein.

6.03 Collection of Charges from Members. Neither Plan nor any Plan Participating Provider shall in any event, including, without limitation, nonpayment by Local Initiative, insolvency of Local Initiative, or breach of this Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive any form of payment, from any Plan Member for Health Care Services provided pursuant to this Agreement. Neither Plan nor any Plan Participating Provider shall maintain any action at law or in equity against a Plan Member to collect sums owed by Local Initiative to Plan. Upon notice of any violation of this Section 6.03, Local Initiative may take all appropriate action consistent with the terms of this Agreement to eliminate such charges, including, without limitation, requiring Plan and Plan Participating Providers to return all sums improperly collected from Plan Members or their representatives, and to the extent such violation is by Plan or with Plan's knowledge, Local Initiative may terminate this Agreement pursuant to Section 7.02(b). Plan's obligations under this Section 6.03 shall survive the termination of this Agreement with respect to Health Care Services provided during this term of the Agreement without regard to cause of termination of this Agreement.

Each contract between Plan and a Plan Participating Provider shall provide that in the event that Plan fails to pay the applicable Participating Provider, the Plan Member shall not be liable to the Participating Provider for any sums owed by Plan. In addition, Plan agrees to hold harmless the State of California and DHCS in the event of nonpayment by Local Initiative for Health Care Services provided to Plan Members.

6.04 Reinsurance. The cost of Plan stop loss/reinsurance coverage shall be the Plan's sole financial responsibility. Unless otherwise mutually agreed by the parties, Plan shall obtain and maintain reinsurance with respect to Health Care Services as reasonably determined by Plan and in accordance with all DHCS and DMHC requirements. Plan shall notify Local Initiative of its reinsurance coverage and any material changes in such coverage.

As between the Local Initiative and Plan, as required in Section 53863 of Title 22, California Code of Regulations), Assumption of Risk, the Local Initiative shall bear the financial responsibility for all qualified expenditures which in aggregate annually exceed 115% of the specified total expenditures (capitation) made under Section 6.01(a) of this Agreement by Local Initiative to Plan during such year. Qualified expenditures are limited to the then-current Medi-Cal fee-for-service equivalent cost of Health Care Services (i.e., services which are covered benefits under the Local Initiative Medi-Cal Plan) actually provided to Plan Members during such year. This process shall be more fully set forth in Local Initiative policies and procedures.

6.05 a) Recoupment Rights. Except as otherwise specifically provided in this Agreement, Local Initiative shall have the right to immediately recoup any and all amounts owed by Plan to Local Initiative (whether by judgment against Plan, or by virtue of actual payment by Local Initiative on behalf of Plan against amounts, including Capitation Payments, owed by Local Initiative to Plan. All amounts paid by Local Initiative to Plan

pursuant to this Agreement shall constitute advances against amounts payable pursuant to the provisions of this Agreement, and upon ten (10) calendar days written notice by Local Initiative to Plan,) shall remain subject to recoupment by Local Initiative against amounts owing by Plan, including but not limited to any amounts owing by Plan as a result of overpayment, retroactive adjustment, Local Initiative's imposition of sanctions under Section 5.01, or Plan's failure to make timely payment for Health Care Services as required herein. Plan acknowledges that all amounts payable under this Agreement, or any predecessor or successor agreement between Plan and Local Initiative, arise out of a single transaction irrespective of the applicable accounting period or any distinction between the specific agreement under which such obligations arise. As a material condition to Local Initiative's obligations under this Agreement, Plan agrees that all recoupment and any offset rights pursuant to this Agreement shall be deemed to be and shall constitute rights of recoupment pursuant to applicable provisions of Title 11 of the United States Code, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority which may now or hereafter have jurisdiction over Plan, nor shall such rights be subject to the automatic stay of 11 U.S.C. §362.

b). Recoupment for Rate Implementation Delay. Plan understands and agrees that Local Initiative shall recoup from Plan the difference between: 1) the aggregate Capitation Payment actually made to Plan by Local Initiative for the period of October 1, 2009 through December 31, 2009; and 2) any compensation which Plan would have been paid for the same period pursuant to Exhibit 6 of this Agreement.

ARTICLE VII
TERM AND TERMINATION

7.01 Term. The term of this Agreement shall be from January 1, 2010 through September 30, 2012, unless terminated sooner as provided in this Agreement. The parties shall endeavor to enter into negotiations regarding extension of this Agreement not less than one hundred eighty (180) calendar days prior to the end of the term of this Agreement. Nothing herein shall limit Local Initiative's authority to enter into contracts with any other health care service plan, provider or health care organization as determined by Local Initiative in its sole discretion. Local Initiative and Plan shall notify DHCS of any termination under this Section 7.01. Notwithstanding the foregoing, this Agreement may be terminated at any time upon mutual written consent of Local Initiative and Plan. In addition, either party may terminate this Agreement without cause upon one hundred eighty (180) calendar days prior written notice to the other party.

7.02 Termination by Local Initiative. Notwithstanding any right of Local Initiative to impose sanctions upon Plan pursuant to any other provision of this Agreement, Local Initiative shall have the right to terminate this Agreement immediately, or as otherwise indicated by Local Initiative upon written notice to Plan in the following circumstances:

(a) revocation, suspension or expiration of Plan's license as a Health Care Service Plan pursuant to the Knox-Keene Act;

(b) Plan's breach of any material term, covenant or condition of this Agreement and subsequent failure to cure such breach, if curable, within thirty (30) calendar days after notice by Local Initiative of such breach; the remedy of such breach within thirty (30) calendar days of receipt of such notice shall revive this Agreement for the remaining term, subject to any of the rights of termination contained in this or any other provision of this Agreement;

(c) Plan's material failure to comply with Medi-Cal Agreement, the Knox-Keene Act or regulations promulgated thereunder or the laws and regulations governing the Medi-Cal Program, as evidenced by a deficiency notice or cease and desist letter from DMHC or DHCS, and failure to cure such material failure within forty-five (45) calendar days of the receipt of such notice from DMHC or DHCS or within such other time period as may be set by DMHC or DHCS ("cure period"). Plan shall be deemed to have cured such a material failure in the event, within such cure period, Plan has submitted a corrective action plan to the applicable regulatory agency and the regulatory agency has accepted such corrective action plan.

(d) Plan's material noncompliance with the Local Initiative, DHCS or DMHC performance standards, subject to Plan's right to review or appeal of a determination of material noncompliance in accordance with Local Initiative policies and procedures.

(e) Plan's material noncompliance with any representations and warranties set forth in this Agreement.

(f) DHCS' failure to pay Local Initiative any amounts due under the Medi-Cal Agreement for Health Care Services for a period of sixty (60) calendar days after the due date of such payment.

(g) The Insolvency of Plan, and Plan's failure to render itself solvent or otherwise remove the conditions causing or constituting the Insolvency within thirty (30) calendar days after notification by Local Initiative of such Insolvency.

(h) Plan's election to commence operations under a Medi-Cal Commercial Plan contract for Los Angeles County pursuant to Section 2.01(b). The termination of this Agreement pursuant to this Section 7.02(h) shall only occur subsequent to the six (6) month notice period and the transition of Medi-Cal Members by Plan as provided in Section 2.01(b).

7.03 Plan's Right to Termination. Plan shall have the right to terminate this Agreement immediately upon written notice to Local Initiative in the following circumstances:

(a) revocation, suspension or expiration or Local Initiative's license as a health care service plan pursuant to the Knox-Keene Act;

(b) Local Initiative's breach of any material term, covenant or condition of this Agreement and subsequent failure to cure such breach within thirty (30) calendar days after notice by Plan of such breach. The remedy of such breach within thirty (30) calendar days of receipt of such notice shall revive this Agreement for the remaining term, subject to any of the rights of termination contained in this or any other provision of this Agreement; or

(c) Local Initiative's material failure to comply with the Medi-Cal Agreement, the Knox-Keene Act or the regulations promulgated thereunder or the laws and regulations governing the Medi-Cal Program, as evidenced by a deficiency notice or cease and desist letter from DMHC or DHCS, and failure to cure such material failure within forty-five (45) calendar days of the receipt of such notice from DMHC or DHCS or within such other time period as may be set by DMHC or DHCS ("cure period"). Local Initiative shall be deemed to have cured such a material failure in the event, within such cure period, Local Initiative has submitted a corrective action plan to the applicable regulatory agency and the regulatory agency has accepted such corrective action plan.

(d) DHCS' failure to pay Local Initiative any amounts due under the Medi-Cal Agreement for Health Care Services for a period of sixty (60) days after the due date of such payment.

(e) the Insolvency of Local Initiative and Local Initiative's failure to render itself solvent or otherwise remove the conditions causing or constituting the Insolvency within thirty (30) calendar days after notification by Plan of such Insolvency.

7.04 Termination Due to Change in Law; Loss of Waiver. In the event of any change in state or federal law or regulations, including implementation of block grants, which materially affects either party's duties and responsibilities hereunder or will result in a material adverse economic impact on either party, either party upon written notice to the other party may request renegotiation of this Agreement to address such material adverse impact. In the event the parties are unable to agree to an amendment to this Agreement within thirty (30) calendar days after notice of renegotiation, either party may terminate this Agreement by providing ninety (90) calendar days prior written notice to the other party. In addition, the foregoing ninety (90) calendar days notice period shall apply in conjunction with any termination by either party after completion of the Plan appeal process pursuant to Sections 10.05 and 10.06, herein and pursuant to any Plan appeal process as established by Local Initiative. Notwithstanding the foregoing, this Agreement shall terminate immediately upon written notice from Local Initiative to Plan in the event that the DHHS withdraws its approval of any waivers granted which are necessary for operation of the Local Initiative Medi-Cal Plan.

7.05 Termination of Medi-Cal Agreement. This Agreement shall immediately terminate upon termination or non-renewal of the Medi-Cal Agreement. Such termination of obligations shall be accomplished by delivery of prior written notice to Plan of the date upon which such termination shall become effective.

7.06 Notification of DHCS of Amendment or Termination. Local Initiative and Plan each shall notify DHCS in the event of an amendment or termination of this Agreement. Any termination under Sections 7.02 or 7.03 is subject to the prior written approval of DHCS to the extent required by the Medi-Cal Agreement. Notice to DHCS is considered given when properly addressed and deposited in the United States Postal Services as first-class registered mail.

7.07 Termination of Plan Member. Termination of a Plan Member shall be in accordance with the terms of the Local Initiative Medi-Cal Plan and, except for a termination from Plan resulting from the Plan Member's request to transfer to another Local Initiative Plan Partner or Local Initiative, shall be upon mutual consent of Plan and Local Initiative.

7.08 Effect of Termination.

(a) Continuing Care Period. Plan shall continue to provide Health Care Services to Plan Members as required by this Agreement after the effective date of termination of this Agreement pursuant to Sections 7.01, 7.02, 7.03 and 7.04 until either (i) such services are complete or the Plan Member can be safely transferred to the care of another provider and such transfer does not violate state laws regarding abandonment of patients, or (ii) Local Initiative has made provisions for the assumption of such services, whichever occurs first. Local Initiative shall use its best efforts to provide for the assumption of such services as soon as is reasonably practicable, taking into account the best interests of the member and the availability of appropriate providers. Compensation to Plan during this continuing care period will be compensated at the DHCS Medi-Cal fee schedule from date of termination.

(b) Termination of the Medi-Cal Agreement. In the event this Agreement is terminated due to termination of the Medi-Cal Agreement, Plan and Plan Participating Providers shall continue to provide Health Care Services and cooperate with the transfer of Plan Members in accordance with the Turnover and Phase-out requirements of the Medi-Cal Agreement. If DHCS withholds Capitation Payments from Local Initiative in connection with such termination, Local Initiative is authorized to withhold from Plan a proportionate amount of any Capitation Payments otherwise due to Plan under this Agreement and such amount shall not be due and owing to Plan until and unless DHCS ceases to withhold such payments from Local Initiative.

(c) Local Initiative Contractual Obligation to DHCS. Termination of this Agreement shall not terminate the Local Initiative's contractual obligations to DHCS.

ARTICLE VIII
INSURANCE AND INDEMNIFICATION

8.01 Insurance.

(a) Plan Insurance. Plan shall maintain professional liability insurance and general liability and errors and omissions liability insurance in at least the minimum amounts acceptable

to DHCS and DMHC for coverage of Plan, its agents and employees. In the event Plan procures a claims made policy as distinguished from an occurrence policy, Plan shall procure and maintain prior to termination of such insurance, continuing extended reporting coverage for the maximum terms provided in the professional liability policy. Plan shall maintain Workers Compensation insurance in the amounts required by law. Plan shall notify Local Initiative of any material changes in insurance coverage and shall provide a certificate of such insurance coverage to Local Initiative upon request. Plan shall require its Plan Participating Providers to maintain insurance consistent with the standards of the relevant community; provided that an FQHC which is covered under the Federal Tort Claims Act shall be deemed to meet the requirements of this sentence.

Notwithstanding the above, and in accordance with California Government Code Section 989-001.2, County Code Chapter 5.32, and Articles 1 and 2 of the Los Angeles County Charter, the Plan is authorized to self-insure for its liability and to meet the requirements of this Article, unless otherwise required by the DMHC or DHCS. This self-insurance may include coverage for legal liability and defense costs for claims asserted by third parties for bodily injury and property damage, including general and professional liability (errors and omissions) and workers compensation benefits.

(b) Local Initiative Insurance. Local Initiative shall maintain professional liability insurance and general liability and errors and omissions liability insurance in at least the minimum amounts acceptable to DHCS and DMHC for coverage of Local Initiative, its agents and employees. In the event Local Initiative procures a claims made policy as distinguished from an occurrence policy, Local Initiative shall procure and maintain prior to termination of such insurance, continuing extended reporting coverage for the maximum terms provided in the professional liability policy. Local Initiative shall maintain Workers Compensation insurance in the amounts required by law. Local Initiative shall notify Plan of any material changes in insurance coverage and shall provide a certificate of such insurance coverage to Plan upon request.

8.02 Indemnification. Local Initiative and Plan will indemnify and hold each other harmless against any claims, demands, damages, liability, judgments and expenses, including reasonable attorneys' fees, as follows:

(a) To the extent that any allegations against Plan are based on alleged fault by Plan (or its agents or employees) in providing or failing to provide Health Care Services to Plan Members or in other administrative dealings with Plan Members, and the allegations against Local Initiative are based on vicarious, passive or secondary liability, including without limitation negligent selection, Plan will fully indemnify Local Initiative against such claims, including reasonable attorneys' fees and costs.

(b) To the extent that any allegations against Local Initiative are based on alleged fault by Local Initiative (or its agents or employees) in providing or failing to provide Health Care Services to Members or otherwise failing to perform under the Medi-Cal Agreement or under the Local Initiative Medi-Cal Plan, and the allegations against Plan are based on vicarious,

passive or secondary liability, including without limitation negligent selection, Local Initiative will fully indemnify Plan against such claims, including reasonable attorneys' fees and costs.

(c) To the extent of any other claims, including without limitation, Plan Participating Provider claims arising from any action taken pursuant to Section 4.02(g) hereof, Plan and Local Initiative will mutually indemnify each other, including reasonable attorneys' fees and costs, in proportion to the relative degree of each party's fault that contributed to the claim. In interpreting this Section 8.02(c), the principles of comparative fault shall apply.

(d) A party seeking indemnification under Section 8.02 shall notify the party required to provide indemnification, in writing, of any claim requiring indemnification under Section 8.02. The indemnifying party shall have the opportunity, at its own expense, to arrange and direct the defense of any action or lawsuit related to any such claim. Upon request of the indemnifying party in defending any claim, the party to be indemnified shall provide the indemnifying party with all information and assistance that is reasonably necessary for the indemnifying party to defend the claim.

ARTICLE IX.
RECORDS AND DATA COLLECTION

9.01 Maintenance of Records. Plan shall maintain and provide to Local Initiative, DHCS and DMHC all books and records and information as may be necessary for compliance by Local Initiative and Plan with the requirements of DHCS and DMHC, including information specified by DHCS related to the Tobacco Lawsuit, in such form and containing such information as required by applicable state law (and in accordance with usual and customary practices in the United States), DHCS, DMHC, and the Medi-Cal Agreement, including financial records and books of account; all medical records, medical charts and prescription files; subcontracts; and any other documentation pertaining to medical and non-medical services rendered to members and such other information as reasonably requested by Local Initiative, or as DHCS or DMHC may require, or as necessary to disclose the quality, appropriateness or timeliness of Health Care Services provided to Plan Members under this Agreement. Plan shall be entitled to reimbursement for Tobacco Lawsuits records as provided by the Medi-Cal Agreement. The obligations created by this Section 9.01 shall not terminate upon the termination of this Agreement without regard to cause of termination.

Local Initiative and Plan shall keep and maintain their books of account and records on a current basis in accordance with general standards for book and record keeping. Local Initiative and Plan shall preserve for a period of not less than five (5) years from the close of the DHCS fiscal year in which this Agreement expires or terminates, the books of account, encounter data, and other records required by this Agreement, the Knox-Keene Act, the laws governing the Medi-Cal Program, DHCS and DMHC; provided that in the event Local Initiative informs Plan that DHCS, the Department of Health and Human Services (DHHS), the Department of Justice (DOJ) or the Comptroller General of the United States have commenced an audit or investigation of Local Initiative, Plan or this Agreement, such books and records shall be preserved until such time as the matter under audit or investigation has been resolved, whichever is later.

9.02 Right to Inspect. Plan shall make available for inspection, examination or copying by Local Initiative, DHCS, DMHC, DHHS or DOJ, at all reasonable times at Plan's place of business or at such other mutually agreeable location in California all books, papers and records relating to the Health Care Services provided to Medi-Cal Members by Plan under this Agreement or otherwise relating to Plan's performance of this Agreement, including but not limited to Plan Member patient records, subject to the confidentiality restrictions set forth in Section 9.03, and financial records pertaining to the cost of operations and income received for Health Care Services provided to Members. The right of DHCS to inspect, evaluate and audit shall extend through five (5) years from the date of termination of this Agreement.

Plan will allow DHCS, DHHS, the Comptroller General of the United States, DOJ, Bureau of Medi-Cal Fraud and other authorized state agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Agreement, and to inspect, evaluate and audit any and all books, records and facilities maintained by Plan and Plan Participating Providers pertaining to these

services at any time during normal business hours, subject to the confidentiality restrictions set forth in Section 9.03. Books and record include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Agreement including working papers, reports, financial records, and books of account, medical records, prescription files, Plan Subcontracts, and any other documentation pertaining to medical and nonmedical services for Plan Members. Upon request, at any time during the period of this Agreement, Plan will furnish any record, or copy of it, to DHCS or DHHS.

Plan shall maintain and make available to DHCS and the Local Initiative, upon request, copies of all Plan Subcontracts and management subcontracts. Plan shall ensure that all such subcontracts are in writing and require the subcontractor, (a) to make all applicable books and records available at all reasonable times for inspection, examination or copying by DHCS, the Local Initiative, or other authorized state and federal agencies; and (b) to retain such books and records for a term of at least five (5) years from the close of the fiscal year in which the subcontract is in effect.

9.03 Confidentiality. Plan and Local Initiative shall maintain the confidentiality of Plan Member medical records and related information in accordance with applicable federal, state and local laws, including, without limitation, Title 42, Section 431.300, *et seq.*, of the Code of Federal Regulations, and California Welfare and Institutions Code Section 14100.2 and the regulations promulgated thereunder. Plan and Local Initiative shall establish and maintain procedures and safeguards so that information pertaining to Medi-Cal Members contained in Plan's or Local Initiative's records or obtained from DHCS in carrying out the terms of this Agreement shall be protected from unauthorized disclosure and so that no member specific information shall be used or disclosed by Plan or Local Initiative or their agents or employees other than for purposes directly connected with the administration of the Local Initiative Medi-Cal Plan. Subject to the confidentiality restrictions set forth herein, Plan Member medical records shall be made readily available as necessary to provide continuity of care to Plan Members.

9.04 Financial Statements. Plan shall provide to Local Initiative copies of the quarterly financial reports and statements submitted by Plan to DMHC. Plan also shall provide Local Initiative with copies of its annual audited financial statements. Plan's quarterly financial statements shall be due to Local Initiative within forty five (45) calendar days from the end of each fiscal quarter and Plan's audited annual financial statements shall be due to Local Initiative within one hundred twenty (120) calendar days from the end of Plan's fiscal year. As used herein, the terms financial statement and financial report shall include documentation of the Plan's and Plan Participating Provider's liability for incurred but not reported ("IBNR") claims calculated using a method in accordance with Title 28, California Code of Regulations, Section 1300.77.2. Upon Local Initiative's request, Plan shall have thirty (30) calendar days to obtain and provide to Local Initiative quarterly and annual audited financial statements of any of its Plan Participating Providers, or at Local Initiative's sole option, Plan shall require Plan Participating Provider to provide directly to Local Initiative quarterly and annual audited financial statements of its Participating Plan Providers within thirty (30) calendar days of Local

Initiative's request. In the event Plan Participating Provider does not have audited financial statements, Plan Participating Provider shall provide financial statements which have been compiled or reviewed pursuant to standards in accordance with generally accepted accounting principles ("GAAP") and generally accepted auditing standards ("GAAS"). Plan shall monitor the financial stability of its Plan Participating Providers as required by DHCS, DMHC, and as provided in Exhibit 3, herein, and Plan shall require Plan Participating Provider to allow direct access of its financial books and records to Local Initiative, DHCS or DMHC, as may be requested by any of the foregoing. Plan shall provide Local Initiative with the results of such monitoring activities upon reasonable request of Local Initiative, unless such disclosure is prohibited by law or regulation. Local Initiative shall keep confidential any financial records received pursuant to this Agreement, as may be required by law. Notwithstanding the foregoing, Plan Participating Provider is subject to this Section 9.04 only to the extent it is a Risk Bearing Organization.

9.05 Data Collection. Local Initiative and Plan shall jointly and separately maintain statistical records and data relating to the utilization of Health Care Services by Plan Members as required for the administration of the Local Initiative Medi-Cal Plan and in compliance with all DHCS and DMHC statistical, financial and/or encounter data reporting requirements. Plan's failure to comply with this Section 9.05 shall constitute a breach of a Local Initiative performance standard and subject Plan to sanctions, as provided in Sections 10.06 and Exhibit 5, herein.

9.06 Reports. Plan shall prepare and submit on a timely basis all reports and other forms as are required of Plan by DHCS or DMHC with regard to Plan's provision of Health Care Services to Plan Members or other performance of this Agreement. Plan shall provide any data or other information to Local Initiative on a timely basis as specified by Local Initiative and in the format required by DHCS or DMHC, as may be required by Local Initiative to enable Local Initiative to file all reports and other forms as are required by DHCS and DMHC with regard to the Local Initiative Medi-Cal Plan, including, without limitation, information and reports with regard to Plan Subcontracts with minority, women and disabled veteran business enterprises. Plan shall prepare and submit to Local Initiative additional financial and other reports as reasonably requested by Local Initiative.

9.07 Disclosure of Protected Health Information. In accordance with HIPAA, Public Law 104-191 and regulations promulgated thereunder by DHHS as applicable to Business Associates to protect Protected Health Information, Plan shall enter into with Local Initiative a business associate agreement in the form attached hereto at Exhibit 8 or another equivalent form as approved by Local Initiative. In the event of any conflict between the terms and conditions of Exhibit 8 and the terms and conditions of this Agreement, the terms and conditions of this Agreement shall be the operative terms and conditions. In addition, Plan warrants and represents that it shall comply, and require its Plan Participating Providers to comply, in all respects with all applicable provisions of HIPAA.

ARTICLE X
MISCELLANEOUS PROVISIONS

10.01 Independent Contractors. In the performance of each party's work, duties, and obligations pursuant to this Agreement, each of the parties shall at all times be acting and performing as an independent contractor, and nothing in the Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venturer or principal and agent. Neither Plan nor any agents, officers or employees of Plan are agents, officers, employees, partners or associates of DHCS or the State of California. Nothing in this Section 10.01 shall be construed to constitute a waiver of or otherwise affect any Medi-Cal Member's right to request and receive a fair hearing under applicable federal and state laws and regulations.

10.02 Cooperation. Local Initiative and Plan shall use their best efforts to maintain a cooperative working relationship to ensure smooth operation of the Local Initiative Medi-Cal Plan. The parties hereto shall, at any time before, at or after execution of this Agreement, sign and deliver (or cause others so to do) all such documents and instruments, and do or cause to be done all such acts and things, and provide or cause to be provided all such information and approvals as may be reasonably necessary to carry out the provisions of this Agreement.

10.03 Confidentiality Requirements.

(a) Confidential Information. Both Plan and Local Initiative, and their respective officers, directors, employees, agents and representatives, shall keep in strictest confidence and in compliance with all applicable state and federal laws, the following information (hereinafter defined as "Confidential Information"):

i) any individually identifiable health information or protected health information (as defined pursuant to state or federal law,

ii) any information which has been identified in writing by a party as confidential, including, but not limited to the following:

(A) any matter relating to the business of the other party, including, but not limited to, the other's employees, products, services, Eligibility List , prices, operations, trade secrets, business systems, planning and finance, and practice guidelines;

(B) materials, data, records or other information obtained from the other party during the course of or pursuant to this Agreement; and

(C) any information learned by Plan or Local Initiative while performing obligations under this Agreement, which if provided by the other party, would be required to be kept confidential. Neither Local Initiative nor Plan shall disclose such information unless authorized by the other party, except as provided in subsections (b) and (c) below.

Upon either party's request, the other party shall execute a confidentiality agreement in the format required by such party and shall provide such agreement to such party prior to disclosure of Confidential Information. The parties shall advise all persons or entities authorized to receive Confidential Information of the obligations contained herein and shall take reasonable measures to prevent unauthorized persons or entities from having access to, obtaining, or being furnished with any Confidential Information.

(b) Permitted Disclosures of Confidential Information. Disclosure of Confidential Information in the following circumstances is not prohibited by Section 10:03(a):

i. disclosure to a government agency, as required by applicable law;

ii. disclosure to necessary and appropriate third parties in the ordinary course of performing duties pursuant to this Agreement;

iii. disclosure to JCAHO, NCQA, or other recognized accreditation organizations;

iv. disclosure in connection with legal or government administrative proceedings;

v. disclosure pursuant to legal process or subpoena;

vi. if such Confidential Information now or later becomes generally known to the health care industry or the general public (other than pursuant to a breach of this Agreement);

vii. if such Confidential Information is independently developed by the disclosing party;

viii. if the disclosing party lawfully obtains such Confidential Information from any third party with the good faith belief that such third party lawfully obtained and disclosed this information.; or

ix. if such Confidential Information is later published or generally disclosed to the health care industry or the general public by the party attempting to maintain such information as confidential.

(c) Applicability of Public Access Laws. Plan understands and acknowledges that Local Initiative is subject to State and local laws governing public access to meetings and documents. Plan further acknowledges that Local Initiative may receive requests for copies of Confidential Information that Local Initiative has received under this Agreement pursuant to these laws. Nothing in this Agreement shall prohibit Local Initiative from disclosing Confidential Information as required pursuant to these laws. However, Local Initiative agrees to:

i. inform Plan if it receives a request disclosure of Confidential Information covered by this Agreement;

ii. to confer with Plan regarding the request;

iii. if Plan and Local Initiative agree that the Confidential Information fall within an exception to public disclosures requirements, to refuse to disclose the Confidential Information; and

iv. if Plan believes that the Confidential Information is not legally required to be disclosed but Local Initiative disagrees with that position, to give Plan notice of its position so that Plan , if it desires, can pursue any available legal remedies in accord with this Agreement.

(d) Indemnification by Plan. Plan shall pay for any costs incurred in pursuing any available legal remedies as described in subsection (c) above and shall indemnify and hold Local Initiative harmless against any claims, demands, damages, liability, court costs, judgments and expenses, including reasonable attorney's fees imposed by a court or otherwise incurred by Local Initiative arising from Plan's attempts to refuse to produce Confidential Information. This notwithstanding**,** should Plan fail to respond to Local Initiative's notices under subsection 10 (c) in a timely manner or fail to comply with any provision of applicable law to obtain appropriate relief from the request for disclosure, Local Initiative shall be free to comply with the request for information and Plan shall waive all rights pursuant to subsection (c) and shall be prohibited from objecting or otherwise attempting to inhibit or prevent the disclosure of the requested information. Local Initiative reserves the right to coordinate activities contemplated pursuant to Section 10.03 (c) in accordance with Local Initiative policies and procedures, as adopted pursuant to Sections 10.05 and 10.06, and in accordance with this Agreement and applicable laws**.** The indemnification provided in this Section (d) is in addition to the indemnification provided for in Article 8**.**

(e) Eligibility List. Notwithstanding the above, Plan acknowledges Local Initiative's ownership and control of the Eligibility List.

(f) Survival of Obligation. The provisions of Sections 10.03 (a)(b)(c)(d) and (f) shall survive, indefinitely, termination of this Agreement without regard to the cause of termination of this Agreement. Section 10.03 (e) shall survive termination of this Agreement for a minimum period of five (5) years, or for such time that Local Initiative continues to exercise ownership and control of the Eligibility List, whichever is later.

10.04 Assignment. This Agreement and the rights, interests, duties and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by either party nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of the other party. Any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS. For purposes hereof, the term "assignment" shall include any merger, consolidation, or reorganization of Plan or any change of more than forty percent (40%) of the ownership or equity interest in Plan (whether in a single transaction or a series of transactions).

10.05 Amendments.

(a) Amendments to Agreement. Local Initiative may amend this Agreement upon thirty (30) calendar days prior written notice to Plan in order to maintain compliance with applicable federal and state laws and regulations and the Medi-Cal Agreement, or in the event such amendment is required by DHCS or DMHC, and such amendment shall be binding upon Local Initiative and Plan, on the effective date of the mandate, law or regulation, subject to the provisions of Section 10.05(c). Local Initiative shall use reasonable efforts to provide Plan with an opportunity to review and comment upon such amendment prior to any mandated compliance date. This Agreement otherwise may be amended only by mutual written consent of the parties. Any amendment to this Agreement shall be subject to the approval of DHCS and DMHC to the extent required and no amendment shall be effective until such approval has been obtained.

(b) Amendments to Local Initiative Medi-Cal Plan, Performance Standards and Local Initiative Policies and Procedures. Local Initiative may amend the Local Initiative Medi-Cal Plan and the covered benefits thereunder, Local Initiative performance standards, or Local Initiative policies and procedures upon thirty (30) calendar days' prior written notice to Plan, in order to maintain compliance with applicable federal or state laws and regulations, the Medi-Cal Agreement, the DDA or in order to comply with any mandated changes imposed by DHCS or DMHC. Such amendments shall be binding upon Local Initiative and Plan, subject to the provisions of Section 10.05(c). Local Initiative shall use reasonable efforts to provide Plan with an opportunity to review and comment upon such Medi-Cal Plan, performance standards or policies and procedures prior to any mandated compliance date.

(c) Material Amendments. In the event Local Initiative provides notice of a mandated amendment pursuant to Sections 10.05(a) or (b) above, Plan shall be permanently bound by such amendment throughout the term of this Agreement. Plan may provide Local Initiative notice of objection and appeal within thirty (30) calendar days after Plan receives notice of such amendment. Such appeal shall contain those elements required by any Local Initiative policy and procedure. In the event Local Initiative and Plan are unable to agree to an amendment to this Agreement within thirty (30) calendar days after the mandated amendment became effective, either party may terminate this Agreement by providing written notice to the other party. Such termination shall be effective ninety (90) calendar days after the date of such notice, or in such shorter period as may be agreed to by the parties. Notwithstanding the foregoing, Plan's failure to comply with the noticed terms and conditions of the mandated amendment, subsequent to being given notice of the amendment, shall constitute a material breach of this Agreement in accordance with Section 7.02(b) herein. Until the effective date of termination, Plan shall continue to provide Health Care Services to Plan Members in accordance with the terms of this Agreement, as amended, and the Capitation Payment rates then in effect. After the effective date of termination, the continuity of care provisions of Section 7.08(a) herein shall apply.

10.06 Local Initiative Performance Standards and Policies and Procedures. In the event Local Initiative intends to adopt or amend any performance standards or policies and procedures applicable to Plan or Plan Participating Providers which affect a material duty or responsibility

of Plan or its Plan Participating Providers hereunder, but which are not mandated as provided in Section 10.05 herein, Local Initiative shall use reasonable efforts to provide Plan with an opportunity to review and comment upon such performance standards or policies and procedures prior to final implementation by Local Initiative. If Plan provides comments to Local Initiative within the review and comment period, Local Initiative shall provide Plan with a written response to Plan's comments prior to final implementation of any proposed performance standard or policy and procedure. After providing such opportunity, Local Initiative shall provide Plan thirty (30) calendar days prior written notice of the effective date of any such performance standards or policies and procedures, and Plan and its Plan Participating Providers shall be bound thereby. Plan may provide Local Initiative notice of objection and appeal prior to the expiration of the thirty (30) calendar day notice period referenced above. Local Initiative and Plan shall also meet and confer to discuss reasonable resolution of the disputed policy and procedure during the thirty (30) calendar day notice period. In the event Local Initiative and Plan are unable to agree to any performance standard or policy and procedure subsequent to the completion of the appeal process, either party may terminate this Agreement by providing written notice to the other party as provided in Section 7.04, herein. Such termination of this Agreement shall be effective ninety (90) calendar days after the date of such notice, or in such shorter period as may be agreed to by the parties. Notwithstanding the foregoing, in the event Plan does not provide notice of termination under Section 7.04, Plan's failure to comply with the noticed terms and conditions of the performance standard or policy and procedure subsequent to the effective date of the amendment and after completion of any unsuccessful Plan appeal or Plan's waiver of any appeal, shall constitute a material breach of this Agreement in accordance with Section 7.02(b), herein. In the event Plan elects to give notice of termination pursuant to Section 7.04, until the effective date of termination, Plan shall continue to provide Health Care Services to Plan Members in accordance with the terms of this Agreement and the Capitation Payment rates then in effect, provided that the amendments to the performance standards or policies and procedures shall not be applicable to Plan.. After the effective date of termination, the continuity of care provisions of Section 7.08(a) herein shall apply. In the event Plan does not elect to terminate this Agreement under Section 7.04, and after Plan receives notice of an unsuccessful appeal or Plan waives its right to appeal, Plan shall be bound by such amendments to the performance standards or policies and procedures. This Section 10.06 shall not apply to adoption or amendment of any Local Initiative policy and procedure which requires mutual consent or approval of the parties, as otherwise set forth in this Agreement, in order to be effective. In addition, a Local Initiative performance standard or policy and procedures which would require Plan to provide or arrange for medical, hospital or other services to Plan Members which i) are not Health Care Services or which otherwise are not required to be provided by applicable law and ii) would have a substantial adverse financial impact on Plan with respect to the Local Initiative Medi-Cal Plan as reasonably demonstrated by Plan to Local Initiative, shall require approval by Plan in order to be effective.

10.07 Dispute Resolution. In the event of any dispute or disagreement under or pertaining to the purposes or subject matter of this Agreement between the parties hereto, including without limitation, the interpretation and/or requirements of any provision hereof and/or whether a dispute and/or default exists hereunder, but excluding any decision identified herein as being final, the matter shall be resolved in accordance with the procedure set forth below. Such

procedure is agreed upon between the parties recognizing that time is of the essence and efficiency is essential to the resolution of disputes or disagreements hereunder, but also the need to provide for and assure a quality means of resolving any such disputes or disagreements. The provisions of this Section and the dispute resolution procedure set forth herein shall survive the rescission or termination of this Agreement.

(a) Mediation. If the parties are unable to resolve among themselves any dispute or other matter requiring their mutual agreement hereunder, such dispute or matter shall first be mediated by referral for consideration and non-binding recommendation to a panel comprised of two individuals, one of whom shall be selected by Local Initiative and Plan, respectively, and each of whom shall have a demonstrated familiarity with the business and legal aspects of managed care organizations, and Medi-Cal managed care programs. Appointment of each party's representative shall be made within five (5) business days after a party has given notice of a request for the invocation of this Section 10.07(a) and the panel shall be required to complete its review and forward its recommendations to the parties within thirty (30) calendar days of such initial notice. Following the receipt of such report(s) or recommendations as may be provided by such panel, the parties shall act in good faith, in light of such information, in a further attempt to resolve such dispute or matter. The costs of such consultants, who shall be paid a reasonable compensation for their time, shall be borne one-half by the Local Initiative and one-half by Plan.

(b) Arbitration. If the mediation provided for in Section 10.07(a) above cannot be timely completed or does not result in a satisfactory resolution of the matter or dispute, the parties agree to submit such matter or dispute to arbitration as follows:

i. Rules of Arbitration. Such arbitration shall by governed by the provisions of the California Arbitration Act, Sections 1280 through 1294.2 of the California Code of Civil Procedure, as said sections are amended from time to time.

ii. Demand for Arbitration. If a dispute subject to arbitration hereunder should arise, either party may make a demand for arbitration by submitting a demand in writing to the other party. The submission of a dispute to the arbitrator(s) may also be ordered by any Superior Court having jurisdiction.

iii. Arbitrator. Within ten (10) business days following any such election or order to arbitrate, each party shall provide the other with written notice of its designee, who shall be a lawyer actively practicing in Los Angeles County with not less than ten (10) years experience in health care law matters and who shall have committed in writing his or her willingness to timely serve hereunder. Within ten (10) business days after such exchange of such identification of such designees, the designees shall meet and select and identify in writing to each of the parties a third party ("Arbitrator") who shall be a lawyer actively practicing in Los Angeles County with not less than ten (10) years experience in health care law matters who shall have no prior relationship, attorney-client or otherwise, within five (5) years preceding the dispute with any of the parties and who shall have committed in writing his or her willingness to timely serve hereunder, or who is a retired judge actively engaged in alternative dispute

resolution matters in Los Angeles County with not less than ten (10) years experience on the bench and/or in such alternative dispute resolution matters, who shall have no prior relationship, attorney/client or otherwise, with any of the parties, and who shall have committed in writing his or her willingness to timely serve hereunder. In the event that any party fails to timely designate its designee under this Section 10.07(b), such dispute shall thereupon immediately be deemed determined in accordance with the position of the other party, but only so long as such other party has not also failed to timely designate its designee. In the event that such designees are unable to timely select and identify Arbitrator, such designees shall, without further action, automatically be deemed dismissed and the parties hereto shall, within ten (10) business days thereafter, repeat the designation process provided for in this Section 10.07(b).

iv. Place of Arbitration. The arbitration shall take place in the City of Los Angeles, County of Los Angeles, State of California, and the hearing before Arbitrator of the matter to be arbitrated shall be at the time and place within said city as is selected by Arbitrator. Arbitrator shall select such time and place promptly after his or her appointment and shall give written notice thereof to each party at least twenty (20) business days prior to the date so fixed. At the hearing, any relevant evidence may be presented by either party, and the formal rules of evidence applicable to judicial proceedings shall not govern.

v. Arbitrator Authority. Arbitrator shall:(a) have all authority of a court of competent jurisdiction, including the authority to issue injunctive and other orders, including rules of discovery, procedure and evidence, and to award damages; (b) schedule, hear and finally decide in writing any dispute under this Agreement within ninety (90) calendar days after the selection of Arbitrator as provided above, unless good cause is shown establishing that the decision cannot fairly and practically be made within such ninety (90) calendar day period, in which event such period shall be extended for one additional period not exceeding ninety (90) calendar days; (c) designate another person to act in his or her place in any instance in which he or she is unable to act within the mandated time frame; and (d) determine and designate the prevailing and non-prevailing parties to any dispute. Notwithstanding the foregoing, Arbitrator may not award punitive, consequential or indirect damages, and each party hereby waives the right to such damages and agrees to receive and accept only those actual damages directly resulting from the claim asserted.

vi. Fees and Costs. The designated non-prevailing party in any dispute shall be required (a) to fully compensate Arbitrator, and each of the designees, for his or her services hereunder at Arbitrator's and such designees' then respective prevailing hourly rates of compensation, and (b) to fully reimburse the designated prevailing party in any dispute for reasonable attorneys' fees and costs in connection with such dispute, as confirmed by Arbitrator without right of challenge by such non-prevailing party.

vii. Failure to Reach Decision. If Arbitrator fails to reach a decision in the determination of the matter in question within the strict time limits specified, the matter shall be decided by a new Arbitrator who shall be appointed and shall proceed in the same manner, and the arbitration process (but not the mediation) shall be repeated until a decision is finally reached by an Arbitrator.

viii. Limited Judicial Action. The designated prevailing party may, but need not, apply to any court of competent jurisdiction to enter a confirming award as to any Arbitrator decisions pursuant to this dispute resolution procedure. No appeal may be taken from any Arbitrator decision pursuant to this procedure except as provided in Section 1286.2 of the California Code of Civil Procedure, provided that no such appeal shall in any way stay or otherwise delay the effect of the appealed decision.

ix. Injunctive Relief. Either party shall be entitled to pursue such remedies for emergency or preliminary injunctive relief in any court of competent jurisdiction; provided that such party shall, immediately following the issuance of any such emergency or injunctive relief, consent to the stay of such judicial proceedings on the merits pending arbitration of all underlying claims between the parties.

10.08 Notices. All notices, requests or demands required or permitted to be given under this Agreement shall be in writing and shall be delivered to the party to whom notice is to be given either by: (i) personal delivery (in which event such notice shall be deemed given on the date of delivery); (ii) facsimile transmission, with a copy sent by Federal Express or other next day air courier service (in which event such notice shall be deemed given on the date of facsimile delivery as evidenced by a dated confirmation of transmission form from the sender's facsimile machine); (iii) Federal Express or other next day air courier service (in which event such notice shall be deemed given on the business day immediately following deposit with the air courier service); or (iv) first class United States mail, postage prepaid, certified, return receipt requested (in which event such notice shall be deemed given three (3) business days after the date of deposit in the mail), and addressed as follows:

If to Local Initiative:

Local Initiative Health Authority for Los Angeles County
555 West Fifth Street, 29th Floor
Los Angeles, California 90013
Attention: Howard A. Kahn, Chief Executive Officer
Fax Number: 213/438-5724

If to Plan:

Community Health Plan
1000 S. Fremont Ave., Bldg. A-9 East, 2nd Floor Unit 4
Alhambra, California 91803
Attention: Teri Daly Lauenstein, Chief Executive Officer
Fax Number: 626/458-6761
Email: tlauenstein@ladhs.org

Any party or person entitled to notice hereunder may change its address for purposes hereof by giving written notice to the other in the manner specified within this Paragraph.

10.09 Waiver. Any waiver of any of the terms and conditions of this Agreement must be in writing and signed by each of the parties to whom it may be applicable. A waiver of any of the terms and conditions of this Agreement shall not be construed as a waiver of any other terms and conditions hereof. No failure or delay by a party to insist upon the strict performance of any term, condition, covenant or agreement of this Agreement, or to exercise any right, power or remedy hereunder or under law or consequent upon a breach hereof or thereof shall constitute a waiver of any such term, condition, covenant, agreement, right, power or remedy or of any such breach, or preclude such party from exercising any such right, power or remedy at any later time or times.

10.10 Governing Law. This Agreement shall be construed in accordance with the internal laws, and not the law of conflicts, of the State of California applicable to agreements made and to be performed in this State.

10.11 Effect of Headings. The titles or headings of the various paragraphs hereof are intended solely for convenience or reference and are not intended and shall not be deemed to modify, explain or place any construction upon any of the provisions of this Agreement.

10.12 Counterparts. This Agreement may be executed in one or more counterparts by the parties hereto. All counterparts shall be construed together and shall constitute one agreement.

10.13 Number and Gender. Words in the singular shall include the plural, and words in a particular gender shall include either or both genders, when the context in which such words are used indicates that such is the intent.

10.14 Attorneys' Fees and Costs. If any action at law or suit in equity or arbitration is brought to enforce or interpret the provisions of this Agreement or to collect any monies due hereunder, the prevailing party shall be entitled to reasonable attorneys' fees and reasonable costs, together with interest thereon at the highest rate provided by law, in addition to any and all other relief to which it may otherwise be entitled.

10.15 Entire Agreement. This Agreement, together with the attachments hereto, and Letter of Agreement to contract dated September 25, 2009, constitutes the full and complete agreement and understanding between the parties hereto and shall supersede any and all prior written and oral agreements concerning the subject matter contained herein. Further, the recitals set forth above and Exhibits attached to this Agreement are an integral part of this Agreement and are incorporated herein by reference.

10.16 Severability. The provisions of this Agreement are severable, and if any one or more provisions is determined to be illegal, invalid or unenforceable in whole or in part, the remainder of this Agreement and any partially unenforceable provisions to the extent enforceable, shall nevertheless be binding and enforceable.

10.17 Covenant and Condition. Each term and each provision of this Agreement shall be construed to be both a covenant and a condition, and, unless expressly stated to the contrary in this Agreement, each such covenant and condition is intended to be effective throughout the term of this Agreement.

10.18 Ambiguities. The general rule that ambiguities are to be construed against the drafter shall not apply to this Agreement. In the event, that any provisions of this Agreement is found to be ambiguous, each party shall have an opportunity to present evidence as to the actual intent of the parties with respect to such ambiguous provision. In the event, that no agreement is reached as to the actual intent of the provision, the parties can avail themselves of any remedy set forth in this Agreement.

10.19 Third Party Beneficiaries. Neither Members nor any other third parties are intended by the parties hereto to be third party beneficiaries under this Agreement, and no action to enforce the terms of this Agreement may be brought against either party by any person who is not a party hereto.

10.20 Applicable Law and Compliance with Medi-Cal Agreement. This agreement shall be governed in all respects by the law of the State of California and applicable federal law, including, without limitation, the Knox-Keene Act and regulations and the federal and state laws and regulations governing the Medi-Cal Program. Plan shall comply with the terms and conditions of the Medi-Cal Agreement as it relates to the arrangement and provision of Health Care Services to Members and shall cooperate fully with the Local Initiative to assist the Local Initiative to remain in compliance with the Medi-Cal Agreement. Any provision that any law, regulation or the Medi-Cal Agreement requires to be in this Agreement shall bind Local Initiative and Plan whether or not specifically provided herein.

10.21 Recitals and Exhibits. The recitals set forth above and Exhibits attached to this Agreement are incorporated herein by reference.

10.22 Confidentiality of Records. To the extent permitted by applicable law, including but not limited to, the California Public Records Act and this Agreement, the records of the Plan relating to the Local Initiative shall be confidential as to third parties.

10.23 Representations and Warranties of Plan. Plan represents and warrants to Local Initiative, as of the date hereof that at the time of execution of this Agreement and to the best knowledge of Plan that:

(a) Knox-Keene Licensure. Plan is a corporation duly organized, validly existing and in good standing under the laws of the State of California. Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is approved as a prepaid health plan by DHCS to provide services to Medi-Cal beneficiaries.

(b) Exclusive Provider Relationships. Except as set forth on Exhibit 7, Plan does not contract and will not contract with any of its providers on an exclusive basis with respect to the provision of services to Medi-Cal beneficiaries in any part or all of Los Angeles County,

California. Plan is not restricted or limited under the terms of any contractual arrangement from directly contracting with any Traditional or Safety Net Provider designated by Local Initiative in Plan's Service Area for the provision of Health Care Services to Plan Members.

(c) Litigation.

i. There is no action, suit or proceeding to which Plan is a party (either as a plaintiff or defendant) pending before any court, governmental agency, authority or body or arbitrator in which it is sought to restrain, prohibit, or to obtain damages or other legal or equitable relief with respect to its business, assets, or properties which could materially affect the consummation of the transactions contemplated by this Agreement or any document or instrument executed in connection therewith, or which could materially affect Plan or any of its assets. Further, to the best knowledge of Plan, there is no such action, suit or proceeding threatened against Plan, and Plan does not believe there is any basis for any such action, suit or proceeding against Plan.

ii. Plan has not been permanently or temporarily enjoined by any order, judgment or decree of any federal, state or local court or governmental agency, authority or body from engaging in or continuing any conduct or practice in connection with the business, assets or properties of Plan related to Plan's performance of this Agreement.

iii. There are no orders, judgments or decrees of any federal, state or local court or other tribunal or other agency enjoining or requiring Plan to take any action of any kind with respect to its business, assets or properties which could materially affect the consummation of the transactions contemplated by this Agreement or any document or instrument executed in connection therewith, or which could materially affect Plan or any of its assets.

(d) Compliance with Law. Plan is in compliance with all federal, state and local laws, ordinances, rules and regulations which are material to the operation of its business operations. Plan has all federal, state or local permits, certificates, licenses and approvals or other authorizations which are material to and required in of its business. No notice has been issued and no investigation, proceeding or action is pending or threatened (i) with respect to any alleged violation of any material federal, state or local law, rule, regulation, policy or guideline, or (ii) with respect to any alleged failure to have all material permits, certificates, licenses, approvals or other authorizations required in connection with Plan's business operations or which would revoke or suspend such items.

(e) Fraud and Abuse. To the best of its knowledge, Plan and its employees, officers and directors (viewed solely in their capacity as employees, officers or directors) have not engaged in any activities which are prohibited under the federal Medicare or Medicaid anti-kickback or false claims laws (including 42 U.S.C. Section 1320a-7b) and the regulations promulgated thereunder, or similar state or local laws, rules or regulations governing fraud and kickbacks, including

i. knowingly and willfully making or causing to be made any false statement or representation of a material fact in any claim for benefit or payment;

ii. knowingly and willfully making or causing to be made any false statement or representation of a material fact for use in determining rights to any benefit or payment;

iii. failing to disclose knowledge by a claimant of the occurrence of any event effecting the initial or continuing right to any benefit or payment on its behalf or on behalf of another with intent to secure such benefit or payment fraudulently; knowingly and willfully soliciting or receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind or offering to pay such remuneration in return:

(A) for referring an individual to a person for furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicare or Medicaid, or

(B) for purchasing, leasing or ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item for which payment may be made in whole or in part by Medicare or Medicaid.

(f) Non-Participation in Commercial Plan. Plan does not, and shall not for the duration of this Agreement, directly or indirectly through subcontract, provide coverage under or otherwise participate in the Commercial Plan. Plan is under no contract or other legal obligation which would prevent Plan from fulfilling this requirement.

(g) Other Information. The representations, warranties and other information concerning Plan set forth in this Agreement, the Exhibits attached hereto and any document, statement or certificate furnished or to be furnished to Local Initiative pursuant hereto, does not and will not, to the best of Plan knowledge, contain any untrue statement of a material fact or omit to state a material fact required to be stated herein or therein or necessary to make the statements and facts contained herein or therein, in light of the circumstances in which they are made, not false or misleading. Copies of all documents heretofore or hereafter delivered or made available to Local Initiative pursuant hereto were or will be complete and accurate copies of such documents.

(h) Survival of Representations and Warranties. The representations and warranties of Plan set forth hereinabove shall be true and correct from the date hereof through the term of this Agreement, and shall survive the termination or expiration of this Agreement.

10.24 Consents and Approvals. Except as otherwise expressly set forth in this Agreement, any consent or approval required of either party hereunder shall not be unreasonably withheld. All decisions and determinations required to be made by either party with respect to performance of its obligations hereunder shall be made in good faith in order to implement the terms and intent of this Agreement. Except as otherwise expressly set forth in this Agreement, any consent or approval required of either party hereunder shall be deemed given unless such party provides

written notification that it does not so consent or approve within thirty (30) business days after receiving the request for such consent or approval.

10.25 Exemption from Automatic Stay. Plan acknowledges that the adequate provision of services to Medi-Cal Members is an essential purpose of this Agreement and that, in any case commenced by or against Plan under Title 11 of the United States Code, any provision of this Agreement relating to the adequacy of services by the Plan to Medi-Cal Members, or to the capability of the Plan to provide services, or similar matters, shall not be construed in a manner such that the exercise by Local Initiative of rights under such provision would constitute a violation of the automatic stay under 11 U.S.C. Section 362. In the event that any such exercise of rights by Local Initiative under such provision should be construed to otherwise constitute a violation of the automatic stay, then Plan hereby stipulates to prospective relief from the automatic stay pursuant to 11 U.S.C. Section 362, and agrees that Local Initiative may enforce all of such rights and remedies notwithstanding such automatic stay, and that Plan will not assert, and hereby waives all right to assert, the existence of a violation of the automatic stay, and further, that Plan will stipulate upon request of Local Initiative to entry of an order clarifying or terminating the automatic stay with respect to such action by Local Initiative.

10.26 Force Majeure. Except as prohibited by Title 28, California Code of Regulations, Section 1300.67.05 or applicable law, neither party shall be liable nor deemed to be in default for any delay or failure in performance under the Agreement or other interruption of service resulting, directly or indirectly, from a catastrophic occurrence or natural disaster, including without limitation, Acts of God, war, accidents, fires, explosions, earthquakes, or labor unrest. However, each party shall utilize its best good faith efforts to perform under this Agreement in the event of any such occurrence or natural disaster.

10.27 Effective Date. The effective date will be January 1, 2010.

10.28 Execution. Local Initiative and Plan represent and warrant, each to the other, that the individuals executing this Agreement on behalf of Local Initiative and Plan, respectively, are each duly authorized to execute and deliver this Agreement on behalf of Local Initiative and Plan, respectively.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement as of the date first set forth above.

Local Initiative Health Authority for Los Angeles County, d.b.a. L.A. Care Health Plan

By: _____
Name: Howard A. Kahn
Title: Chief Executive Officer

Date: _____, 2009

County of Los Angeles as Operator of Community Health Plan,
a California Health Care Service Plan

By: _____
Name: John F. Schunhoff
Title: Interim Director

Date: _____, 2009

By: _____
Name: Thomas S. Klitzner, MD., PhD.
Title: Chairperson, L.A. Care Board of Governors
Date: _____, 2009

Exhibit 1
Service Area

Community Health Plan is licensed to operate as a Health Care Service Plan in all zip codes in Los Angeles County, including but not limited to the zip codes that represent Catalina Island**.**

Exhibit 2

Maximum Enrollment Target

Maximum Enrollment Target: 200,000 Medi-Cal Members

Exhibit 3
Required Plan Subcontract Provisions

I. Required Provisions

The following provisions shall be included in all Plan Subcontracts and shall be required to be in any subcontract between a Plan Participating Provider and any health care provider from which the Plan Participating Provider obtains usual or frequently used Health Care Services on behalf of Plan members. Capitalized terms have the same meaning as set forth in the Services Agreement between Local Initiative and Plan ("Local Initiative Plan Contract"); provided that Plan may use different terminology as necessary to be consistent with the terms used in the Plan Subcontract (*e.g.*, referring to the Plan Subcontract as a "Provider Agreement") so long as such different terminology does not change the meaning hereof.

1. Provision of Health Care Services. Plan Participating Provider shall furnish to Plan Members those Health Care Services which Plan Participating Provider is authorized to provide under this Plan Subcontract, consistent with the scope of Plan Participating Provider's license, certification or accreditation, and in accordance with professionally recognized standards [If the Plan Subcontract is an amendment to a standard Provider Contract between Plan and the Plan Participating Provider, add the following, "and the terms and provisions of the Provider Contract, as amended by the provisions herein (the "Plan Subcontract")"]. Plan Participating Provider shall provide Health Care Services to Plan Members in accordance with, and shall otherwise comply with all of the provisions of, the Services Agreement between Local Initiative and Plan ("Local Initiative Plan Contract") as amended from time to time.

2. Quality Assurance/Improvement Programs. Plan Participating Provider shall cooperate and comply with, and participate in, the quality assurance/improvement programs established (or amended from time to time) by Local Initiative and by Plan, and approved by DHCS and DMHC. In furtherance thereof, Plan Participating Provider shall cooperate with and participate in Local Initiative's monitoring and evaluation activities, and shall, if requested by Local Initiative through Plan, serve on Local Initiative quality improvement subcommittees.

3. Local Initiative Member and Provider Grievance/Appeal Procedure. Plan Participating Provider shall cooperate and comply with the grievance and appeal procedures for review of Plan Member clinical and non-clinical grievances and provider grievances as established (or amended from time to time) by Local Initiative and by Plan and approved by DHCS and DMHC.

4. Utilization Management Program. Plan Participating Provider shall cooperate and comply with and participate in the utilization management programs established (or amended from time to time) by Local Initiative and by Plan and approved by DHCS and DMHC.

5. Excluded Services Linkages; Case Management. Plan Participating Provider shall cooperate and comply with the policies and procedures developed by Local Initiative and Plan with respect to required referral and linkage systems for mental health, dental, California

Children Services, family planning, Indian health services, and Department of Public Health services and any other community health or excluded services in accordance with the requirements of DHCS (as delineated in the Detailed Design Application and Medi-Cal Agreement governing the Local Initiative Medi-Cal Program). Plan Participating Provider shall take such actions as necessary to ensure appropriate case management and continuity of care between the Plan Member's primary care physician and the local health departments or other agencies to which the Plan Member may be referred.

6. Cultural/Linguistic Training Programs. Plan Participating Provider shall participate in and comply with the performance standards, policies, procedures and programs established from time to time by Local Initiative and Plan with respect to cultural and linguistic services, including, without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to Local Initiative and Plan.

[For Traditional and Safety Net Providers Only.] In accordance with the Local Initiative Plan Contract, Plan Participating Provider shall designate on an Exhibit ~~1~~, attached hereto, the linguistic services to be provided to Plan Members and the names of the individuals who will provide such services.

7. Performance Standards. Plan Participating Provider shall comply with all performance standards, policies and procedures as may be adopted or amended from time to time by Local Initiative, in accordance with the Local Initiative Plan Contract, or as may be required by DMHC or DHCS.

8. Sanctions. In the event Local Initiative finds Plan Participating Provider non-compliant with the Local Initiative, DHCS or DMHC performance standards, Local Initiative shall have the power and authority to impose sanctions upon Plan Participating Provider in accordance with, and subject to all appeal rights under, the Local Initiative Sanctions policies and procedures as implemented from time to time by Local Initiative.

9. Disciplinary Action and Termination. Plan Participating Provider acknowledges and agrees that, under the Plan Contract, Local Initiative has the right to require Plan to suspend assignment of new enrollees to Plan Participating Provider, to transfer Plan Members from Plan Participating Provider or require Plan to terminate Plan Participating Provider from the Local Initiative Medi-Cal Plan at any time, subject to such review or appeal rights as may be provided pursuant to the Plan Contract, as amended from time to time.

10. Information. Plan Participating Provider shall promptly provide Plan, or if requested by Local Initiative, provide directly to Local Initiative, financial, capacity, encounter data or other information, reports, documents or forms as may be required to enable Plan to fulfill its reporting and other obligations under the Local Initiative Plan Contract or as otherwise required for purposes of compliance with the Knox-Keene Act, Medi-Cal laws and regulations, the DHCS Detailed Design Application, or the Medi-Cal Agreement.

11. Exclusivity. [NOTE: This Section is applicable only if Plan Participating Provider is a provider of primary care services whose practice(s) or facility(ies) is owned and operated by Plan or which is under exclusive contract to Plan or its related organizations.] For the duration that Plan Participating Provider provides services to Plan Members under the Local Initiative Plan Contract, Plan Participating Provider shall not directly or indirectly participate in the Medi-Cal Commercial Plan for Los Angeles County unless Local Initiative consents in advance in writing.

12. Provider Contract/Plan Contract. Nothing set forth herein shall be deemed to amend, interpret, construe or otherwise affect in any way the Plan Contract, as amended from time to time. To the extent there are any inconsistencies or contradictions between this Plan Subcontract and the Plan Contract, the terms and provisions of the Plan Contract shall prevail and control.

13. Third Party Beneficiary. Plan and Plan Participating Provider acknowledge and agree that the Local Initiative is intended to be benefited by, and shall have the rights of a third party beneficiary under, this Plan Subcontract.

14. Cooperation. Plan Participating Provider shall use its best efforts to maintain a cooperative working relationship to ensure smooth operation of the Local Initiative Medi-Cal Plan. The parties hereto shall, at any time before, at or after execution of this Plan Subcontract, sign and deliver (or cause others so to do) all such documents and instruments, and do or cause to be done all such acts and things, and provide or cause to be provided all such information and approvals as may be reasonably necessary to carry out the provisions of this Plan Subcontract.

15. Assignment. To the extent required by DHCS, any assignment or delegation of this Plan Subcontract shall be void unless prior written approval is obtained from DHCS. Plan Participating Provider acknowledges that the services to be provided by it hereunder are unique and personal to Plan Participating Provider, and that Plan shall not be required to accept performance from anyone other than Plan Participating Provider. Accordingly, this Plan Subcontract is not assignable absent the express written consent of Plan.

16. DHCS Subcontract Approval. If applicable, in the event the Plan is not a qualified HMO pursuant to CCR Title 22 Section 53250(a), any amendment(s) to this Plan Subcontract shall be submitted to DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term of this Plan Subcontract.

17. Books and Records. Participating Plan Provider shall make all applicable books and records available at all reasonable times for inspection, examination or copying by DHCS and retain books and records pertaining to this Plan Subcontract for a term of at least five (5) years from the close of the fiscal year in which this Plan Subcontract is in effect. At Local Initiative's sole option, to the extent Plan Participating Provider is a Risk Bearing Organization, Plan shall require Plan Participating Provider to provide directly to Local Initiative quarter and annual audited financial statements of any of each Plan Participating Provider within thirty (30)

days of Local Initiative's request. In the event Plan Participating Provider does not possess audited financial statements, Plan Participating Provider's financial statements shall be either compiled or reviewed (in accordance with GAAP and/or GAAS) prior to submission to Local Initiative.

18. Compensation. Any compensation paid hereunder to Plan Participating Provider shall comply, in all respects, with California Welfare and Institutions Code Section 14452, including any prohibition on determining the consideration paid hereunder based on a percentage of any payment which the Local Initiative receives from DHCS in order to arrange for the provision of the services contemplated by this Agreement.

19. Claims Payment Standard. Plan Participating Provider shall reimburse, contest or deny all claims consistent with applicable laws, regulations and contractual requirements.

20. Financial Solvency Standards. To the extent Plan Participating Provider is a Risk Bearing Organization, Plan Participating Provider shall be solvent at all times during the terms of this Plan Subcontract and shall maintain the following minimum financial solvency standards:

a) Prepare quarterly financial statements in accordance with generally accepted accounting principles("GAAP") within forty five days after the end of each fiscal quarter;

b) Estimate and document, on a monthly basis, Plan Participating Provider's liability for incurred but not reported ("IBNR") claims using a lag study, an actuarial estimate, or other method as provided by Title 28, California Code of Regulations, Section 1300.77.2.

c) Maintain at all times during the term of this Plan Subcontract, a positive working capital (current assets net of related party receivables, less current liabilities);

d) Except for Plan Participating Providers which are hospitals, maintain at all times during the term of this Plan Subcontract a positive tangible net equity as defined in Title 28, California Code of Regulations, Section 1300.76;

e) Maintain at all times during the term of this Plan Subcontract a minimum cash to claims ratio as defined in and required by Title 28, California Code of Regulations; and

f) Prepare annual financial statements in accordance with generally accepted accounting principle ("GAAP") audited by an independent accounting firm within one hundred fifty (150) calendar days after the end of the fiscal year.

21. HIPAA Regulations. In accordance with the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Public Law 104-191 and regulations promulgated thereunder by the United States Department of Health and Human Services and other applicable laws as may be promulgated and amended from time to time, in order to protect Protected Health Information, Plan shall enter into with its Plan Participating Providers which are Business

Associates, a business associate agreement in the form attached at Exhibit 8 or another equivalent form approved by Local Initiative. The business associate agreement between Plan and Plan Participating Provider shall be subject to the same review and approval by Local Initiative as any Plan Subcontract referenced in Section 4.02 (c) (i), of the Plan Contract.

22. NCQA Standards. Plan Participating Provider shall comply with the NCQA Local Initiative Program as amended from time to time, including but not limited to, freely communicating with Medi-Cal Members about their treatment regardless of benefit coverage limitations and, in the event Plan Participating Provider is a specialist or specialty group, facilitating timely notification to Medi-Cal Members affected by the termination of the Plan Subcontract.

23. Medi-Cal Eligibility Redetermination Date. Plan shall provide Plan Participating Provider with the Medi-Cal eligibility redetermination date(s) of the Plan Members assigned to Plan Participating Provider.

II. Additional Provisions

In addition to the foregoing, Plan shall ensure that its Plan Subcontracts conform and comply with, and include each and every provision required to be in contracts between health care service plans and health care providers under, the Knox-Keene Act and regulations. Plan further shall ensure that its Plan Subcontracts conform and comply with, and include each and every provision required to be in Medi-Cal subcontracts or sub-subcontracts under, the Medi-Cal laws and regulations and the Medi-Cal Agreement. Plan shall ensure that its Plan Subcontracts otherwise conform and comply with, and include any required provisions under, the Plan Contract, as amended from time to time. Such provisions include, without limitation, provision of emergency services; access to, disclosure of, availability for inspection and copying, copying of and retention of books and records; access to premises; non-discrimination; prohibition on the collection of charges; and third party liability payments. To the extent required to comply with the foregoing, Plan and Plan Participating Provider shall amend the Provider Contract or Plan Subcontract, as applicable, to include any such required provisions.

Exhibit 4

Identification of Officers, Owners, Stockholders, Creditors, etc.

[Not Applicable – Owned and operated by the County of Los Angeles]

Exhibit 5

SANCTIONS

I. Performance Standards

Subject to Section 10.06, Plan and its Plan Participating Providers shall comply with all performance standards adopted or amended from time to time by Local Initiative. Such performance standards shall include, without limitation, requirements regarding:

1. Enrollees' satisfaction at levels set forth in the performance standards;
2. Compliance with DHCS and DMHC standards and requirements
3. Investigation and outcomes tracking of significant voluntary disenrollment of Plan Members within any quarter;
4. Submission of encounter data within required time frames;
5. Maintenance of Plan Participating Provider network capacity and accessibility
6. Satisfaction of Plan Participating Providers in network at levels set forth in the performance standards;
7. Timely and appropriate corrective action(s) in response to negative public relations issues;
8. Compliance with Local Initiative marketing policies and procedures;
9. Provision of Medically Necessary health care services, including referrals, to Plan Members; and
10. Compliance with Local Initiative cultural competency and linguistic services performance standards.
11. No findings of serious deficiencies as identified in the medical audits conducted by DHCS.
12. Compliance by Plan with the terms and conditions of the Delegation Agreement.

II. Sanctions

In the event Local Initiative finds Plan or a non-compliant with the Local Initiative performance standards, Local Initiative shall have the power and authority to impose sanctions upon Plan in accordance with the Local Initiative Sanctions policies and procedures as implemented from time to time by Local Initiative. If the Local Initiative finds a Plan Participating Provider non-compliant with the Local Initiative performance standards, Local Initiative shall have the power and authority to impose sanctions upon such non-compliant Plan Participating Provider in accordance with the Local Initiative Sanctions policies and procedures as implemented from time to time by Local Initiative. Local Initiative sanctions which may be imposed upon Plan or any Plan Participating Provider shall include, without limitation:

1. Public notice of a performance deficiency;
2. Freeze of assignment of additional Medi-Cal Members;
3. Withhold of a portion of capitation payments based upon Local Initiative's actuarial analysis of the impact of the performance deficiency;
4. Monetary sanctions for performance deficiencies, in the same manner as provided in the Medi-Cal Agreement for Local Initiative non-performance; and
5. Termination of the Plan or a Plan Participating Provider from the Local Initiative Medi-Cal Plan and/or termination of this Agreement or a Plan Participating Provider's Plan Subcontract.

The Local Initiative Sanctions policies and procedures shall provide (i) that sanctions may, but need not be, progressive; (ii) that capitation withholding may be restored to Plan upon correction of the performance deficiency, with any interest on such withhold being retained by Local Initiative; and, (iii) that Plan shall indemnify and reimburse Local Initiative for any monetary sanctions imposed upon Local Initiative by DHCS due to performance deficiencies of Plan or a Plan Participating Provider. The Sanctions policies and procedures also shall include a process for Plan or, if applicable, Plan Participating Provider, appeal of Local Initiative sanctioning recommendations to the Local Initiative Board of Governors.

Exhibit 6

PLAN PARTNER SERVICES AGREEMENT
COMPENSATION

* The contents of this Exhibit 6 and its related Attachments and Addendum are on file with the Department of Health Services and kept confidential in accordance with Health and Safety Code Section 1457.

Exhibit 7
Plan Exclusive Contracts

County of Los Angeles Clinics Dedicated to Serving Plan Enrollees

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Exhibit 8

BUSINESS ASSOCIATE
HEALTH INFORMATION DISCLOSURE ADDENDUM

This Business Associate Health Information Disclosure Addendum ("Addendum") supplements and is made a part of the Services Agreement, as amended, dated on or about January 1, 2010 ("Agreement") by and between the Local Initiative Health Authority for Los Angeles County, a local government agency d.b.a L.A. Care Health Plan ("Local Initiative") and Community Health Plan, a California health care service plan ("Plan") (collectively referred to herein as "Business Associates" or "the parties."), and is effective as of the compliance date of the Privacy Regulations (defined below) (the "Addendum Effective Date").

RECITALS

WHEREAS, in the course of fulfilling their respective obligations under the Agreement, the parties will be required to disclose certain information to each other, some of which may constitute Protected Health Information; and

WHEREAS, the parties desire to satisfy certain standards and requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including, but not limited to the Standards for Privacy of Individually Identifiable Health Information at Title 45, Code of Federal Regulations, Sections 160 and 164, as such standards and requirements may be amended from time to time ("Privacy Regulations"); and

WHEREAS, the parties agree that they are Business Associates as defined by the Privacy Regulations and desire to impose on each other mutual compliance obligations with regard to such Regulations; and

WHEREAS, the Privacy Regulations require Business Associates to enter into an Agreement in order to mandate certain protections for the privacy and security of Health Information, and those Regulations prohibit the disclosure to or use of Health Information by Business Associates if such an agreement is not in place;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

I. DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision or access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 "Protected Health Information" means any information, whether oral or recorded in any form or medium that: (i) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; (ii) identifies the individual (or for which there is a reasonable basis for believing that the information can be used to identify the individual); and (iii) is received by either Local Initiative or Plan from or on behalf of each other or is created by either party or is made accessible to either Local Initiative of Plan by each other.

1.3 "Health Care Services" has the same meaning as in the Services Agreement.

1.4 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

II. MUTUAL OBLIGATIONS OF BUSINESS ASSOCIATES

2.1 Mutuality of Addendum Provisions**.** The provisions in this Addendum create mutual obligations upon the parties hereto, notwithstanding whether such obligations are stated in the singular or plural. Similarly, the rights created herein shall be mutually conferred among the parties hereto.

2.2 Permitted Uses and Disclosures of Protected Health Information. Business Associates:

(a) shall Use and Disclose Protected Health Information as necessary or appropriate to perform the Health Care Services, and as provided in Sections 2.5, 2.6,.2.7, 2.9, and 2.11 of this Addendum ;

(b) shall disclose Protected Health Information to each other upon request;

(c) may, as necessary for the proper management and administration of their respective business operations or to carry out their legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if (A) the Disclosure is required by law, or (B) Business Associate obtains reasonable assurance from the person to whom the information is Disclosed that the Protected Health Information will be

held confidentially and Used or further Disclosed only as required by law or for the purpose for which it was Disclosed to the person, and the person agrees to notify Business Associate of any instances of which the person is aware in which the confidentiality of the Protected Health Information has been breached.

(d) Business Associate(s) shall not Use or Disclose Health Information for any other purpose.

2.3 Adequate Safeguards for Health Information. Business Associates warrant to one another that they shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

2.4 Reporting Non-Permitted Use or Disclosure. Business Associates shall report to each other each Use or Disclosure that they make, or that is made by, their respective employees, representatives, agents or subcontractors that is not specifically permitted by this Addendum. The initial report shall be made by telephone call to the parties' respectively designated Privacy Officers within forty-eight (48) hours from the time the Business Associate becomes aware of the non-permitted Use or Disclosure, followed by a written report to the Privacy Officer no later than five (5) days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure.

2.5. Availability of Internal Practices, Books and Records to Government Agencies. Business Associates agree to make their internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of the federal Department of Health and Human Services for purposes of determining fulfillment of their respective compliance obligations with the Privacy Regulations.

2.6. Access to and Amendment of Health Information. Business Associates shall, to the extent either party determines that any Protected Health Information constitutes a "designated record set" under the Privacy Regulations, (a) make the Protected Health Information specified by such party available to the individual(s) identified by such party as being entitled to access and copy that Protected Health Information, and (b) make any amendments to Protected Health Information that are requested by either party hereto . Business Associates shall provide such access and make such amendments within the time and in the manner specified by the requesting party.

2.7 Accounting of Disclosures. Upon request, Business Associates shall provide each other an accounting of each Disclosure of Protected Health Information that they make or that is made by their respective employees, agents, representatives or subcontractors. Any accounting provided by Business Associates under this Section 2.7 shall include: (a) the date of the Disclosure; (b) the name, and address if known, of the entity or person who received the Protected Health Information; (c) a brief description of the Protected Health Information disclosed; and (d) a brief statement of the purpose of the Disclosure. For each Disclosure that could require an accounting under this Section 2.6, Business Associates shall track the

information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure.

2.8. Term and Termination. The term of this Addendum shall commence as of the Addendum Effective Date and shall expire or terminate in accordance with the terms of the Agreement, unless otherwise terminated in accordance with the provisions of Section 5 of the Agreement. Notwithstanding the termination provisions set forth in the Agreement, both this Addendum and the Agreement may be terminated immediately, by either party, upon written notice to the breaching party, if the non-breaching party determines, in its sole discretion that the breaching party has violated any material term of this Addendum. Business Associates' obligations under Sections 2.2 (as modified by Section 2.9), 2.4, 2.5, 2.6, 2.7, 2.9 and 2.11 shall survive the termination or expiration of this Addendum.

2.9 Disposition of Health Information Upon Termination or Expiration. Upon termination or expiration of this Addendum Business Associates shall either return or destroy, in each party's sole discretion and in accordance with any instructions by such party all Health Information in the possession or control of Business Associate or its agents and subcontractors. However, if Covered Entity determines that neither return nor destruction of Health Information is feasible, Business Associate may retain Health Information provided that Business Associate (a) continues to comply with the provisions of this Agreement for as long as it retains Health Information, and (b) further limits Uses and Disclosures of Health Information to those purposes that make its return or destruction infeasible.

2.10. No Third Party Beneficiaries. There are no third party beneficiaries to this Agreement.

2.11. Use of Subcontractors and Agents. Business Associates shall require each of their respective agents and subcontractors to whom they disclose Protected Health Information to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

2.12. Mutual Indemnification. The Parties hereto will mutually indemnify and hold harmless one another, their respective agents and subcontractors from and against any liability or claim (regardless to form) that may arise as a result of their respective negligent acts or omissions in violation of the terms of this Addendum. This notwithstanding, the Parties shall be solely responsible for their own decisions regarding the safeguarding of Protected Health Information.

2.13. Injunctive Relief**.** Notwithstanding any rights or remedies provided for in this Agreement, the parties hereto shall retain all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of Protected Health Information by one another, or their respective agents, contractors, subcontractors, or any third party that received Protected Health Information from either party hereto.

2.14. Amendment(s) to this Addendum**.** The Parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The

Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the Privacy Regulations and other applicable laws relating to the security or confidentiality of Protected Health Information.

2.15 Relationship to Agreement Provisions. This Addendum shall be construed under, and in accordance with, the terms of the Agreement. This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and the Privacy Regulations. The Parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the Privacy Regulations.

2.16 Entire Addendum**.** This Addendum consists of this document, and constitutes the entire agreement between the Parties with respect to the subject matter herein. There are no understandings or agreements relating to this Addendum which are not fully expressed herein and no change, waiver or discharge of obligations arising under this Addendum shall be valid unless in writing and executed by the party against whom such change, waiver or discharge is sought to be enforced.

Exhibit 9

Local Initiative Additional Responsibilities

NOT APPLICABLE AT THIS TIME

Exhibit 10

NCQA DELEGATION AGREEMENT

This Agreement ("Delegation Agreement") is entered into and effective as of this 1st day of January 2010, and between Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan (hereinafter "Local Initiative"), a local governmental agency, and **Community Health Plan**, a California health care service plan (hereinafter "Plan" and/ or "Plan) and amends the Plan Partner Services Agreement ("Services Agreement") between Local Initiative and Plan.

RECITALS

WHEREAS, Local initiative and Plan have entered into that Services Agreement dated January 1, 2003, as amended, of which this Delegation Agreement is incorporated by reference and made a part thereof;

WHEREAS, pursuant to the Medi-Cal Agreement, Local Initiative has agreed to arrange for or provide certain health services and functions under the Medi-Cal Managed Care Program to Medi-Cal beneficiaries who may enroll in the Local Initiative Medi-Cal Plan;

WHEREAS, pursuant to the Services Agreement and Local Initiative policies and procedures, Local Initiative has delegated to Plan the obligation to provide certain health services and functions ("Delegated Activities") under the Medi-Cal Managed Care Program to Medi-Cal beneficiaries who may enroll in the Local Initiative Medi-Cal Plan:

WHEREAS, in accordance with National Committee for Quality Assurance ("NCQA) standards and guidelines, Local Initiative and Plan wish to memorialize Local Initiative's delegation of the performance of certain NCQA functions ("Delegated Activities") to Plan and also to memorialize Local Initiative's oversight of Plan 's performance of those same functions;

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree as follows:

1. Appointment. Local Initiative engages and appoints Plan to perform the Delegated Activities as set forth in the Services Agreement, including but not limited to Article IV of the Services Agreement (which Services Agreement is incorporated herein by reference), as well as Section 3 of this Delegation Agreement, and Plan accepts such appointment on the terms and conditions hereof. The parties hereto intend and agree that all terms and conditions contained in this Delegation Agreement shall supplement and be in addition to those terms and conditions contained in the Services Agreement. In the event of any conflict between the terms and conditions of the Services Agreement and this Delegation Agreement, the terms and conditions of this Delegation Agreement shall prevail provided that all other applicable federal and state laws and regulations as well as all requirements delineated in the Services Agreement are otherwise met by Plan.

2. Term and Renewal and Amendment.

2.1 Term. The term of this Delegation Agreement shall commence on the date set forth above and shall continue until the termination of the Services Agreement (as provided for in Article VII of the Services Agreement) or termination of this Delegation Agreement (as provided for in Section 9 herein), unless terminated earlier as provided in Article X of the Services Agreement or Section 9 of this Delegation Agreement.

2.2 Amendments. This Delegation Agreement may be modified or amended pursuant to Section 10.05 of the Services Agreement.

3. Responsibilities of Plan.

3.1 Performance of Delegated Activities. Plan agrees to perform the Delegated Activities described in Attachment "A" and services reasonably related or ancillary thereto in accordance with the procedures described in Plan's Program Documents and in accordance with Local Initiative's quality improvement ("QI") program, utilization management ("UM") program, credentialing ("CR") program and member rights and responsibilities ("MRR") program (sometimes hereinafter collectively referred to herein as "Local Initiative Programs")

3.2 Submission of Reports. Plan agrees to provide the reports described in Attachment "B" in a form and format approved or specified by Local Initiative**.**

3.3 Cooperation with Audits. Plan agrees to permit Local Initiative to conduct annual, or more frequent, on site audits of Plan's performance of Delegated Activities. Such audits may include, without limit, interviews with staff; review of Plan's policies, procedures, files, personnel records, program descriptions, work plans and other relevant documents; observation of Plan's staff or agents performing tasks related to the Delegated Activities.

3.4 Local Initiative's Attendance at Meetings. Plan agrees to permit Local Initiative to attend meetings of Plan's staff where activities relevant to the Delegated Activities are presented.

3.5 Compliance with NCQA Standards. Subject to Section 4.1.2, below, Plan agrees to comply with the Standards and Guidelines for the Accreditation of Local Initiative ("NCQA Standards") promulgated by the NCQA as amended from time to time. Plan agrees to expend all reasonable effort to cooperate with and assist Local Initiative in demonstrating Local Initiative's and Plan's compliance with said NCQA Standards, including but not limited to, granting Local Initiative access during business hours to all relevant information pertaining to the Delegated Activities and Plan's performance thereof.

3.6 Health Services Contracting. Pursuant to Section 3.5, above, Plan understands and agrees that: (a) Plan Subcontracts shall include an affirmative statement indicating that Plan Participating Providers may freely communicate with Medi-Cal Members about their treatment regardless of benefit coverage limitations; and (b) Plan Subcontracts between Plan and its contracted specialists shall require timely notification to Medi-Cal Members affected by the termination of a specialist or the entire specialty group.

3.7 Participation in Related Activities. Plan agrees to participate in meetings, projects or other tasks or activities related to the Delegated Activities, or services reasonably related or ancillary thereto, as may from time to time be reasonably requested by Local Initiative.

4. Responsibilities of Local Initiative.

4.1 Oversight by Local Initiative. Local Initiative retains authority and oversight for all Delegated Activities and full and final authority and responsibility for the administration of its health care benefit plans and the operation thereof. In addition to Local Initiative's responsibilities as described in Attachment "A," Local Initiative shall perform, and Plan agrees to permit Local Initiative to perform, the following activities:

4.2 Pre-Delegation Audit. Local Initiative shall review Plan's policies and procedures, program description, work plan and other documents (the "Program Documents") describing Plan's procedures for performing the Delegated Activities to determine if they comply with the current Local Initiative Program requirements. Prior to the performance of any Delegated Activities, Local Initiative must determine that Plan's Program Documents comply with the current Local Initiative Program requirements. If such Program Documents are not in compliance with the current Local Initiative Program requirements, Plan must submit, implement, and fully execute a plan of correction acceptable to Local Initiative.

4.3 Amendments to Local Initiative Program Requirements. Plan understands and agrees that Local Initiative may amend the Local Initiative Program requirements from time to time, pursuant to Section 10.06 of the Services Agreement. Notwithstanding Section 10.06 of the Services Agreement and Section 2.2 of this Delegation Agreement, in the event the Local Initiative Program is amended, Local Initiative shall provide Plan with ninety (90) calendar days' written notice of the effective date of any such amendment. Then, to the extent the revised Program Requirements contain completely new standards, the parties shall meet and confer during the ninety (90) day notice period to determine whether or not those new standards shall be delegated to Plan or retained by Local Initiative. If, after the meet and confer period set forth above, the Plan and

Local Initiative are unable to agree on whether or not new NCQA standard(s) shall be delegated to the Plan or retained by Local Initiative, then the following shall apply: (a) If the new NCQA standard[s] is integral to a function[s] already delegated to Plan, then the new NCQA standard[s] will become the responsibility of Plan and become a Plan delegated function[s]; or (b) If the new NCQA standard[s] is separable and not integral to a function[s] already delegated to Plan, then the new NCQA standard[s] will be retained by and become a Local Initiative responsibility. In the event Local Initiative retains the new NCQA standard(s), then Local Initiative shall determine its cost of providing and/or implementing such NCQA standards on behalf of Plan and Plan agrees to reimburse Local Initiative for such cost. Upon the express written request of Plan, Local Initiative shall invoice Plan for such cost. Otherwise, such cost shall be deducted by Local Initiative from Plan's Capitation Payment. The parties understand and agree that Local Initiative shall determine, in its sole reasonable discretion, which new NCQA standard[s] is separable or integral.

4.4 Review of Program Documents. Local Initiative shall conduct an annual review of the Plan's Program Documents including policies and procedures, program description, work plan and other documents related to the Delegated Activities. Local Initiative shall review, in advance, any proposed changes to Plan's Program Documents, including changes made in order to comply with Local Initiative Program requirements or the NCQA Standards.

4.5 On-Site Audit. At least annually, Local Initiative shall conduct an on-site audit of Plan's performance of the Delegated Activities to evaluate Plan's compliance with Local Initiative program requirements, the requirements described in this Agreement, and with the NCQA Standards.

4.6 Review of Reports. Local Initiative shall review the reports submitted by Plan as described in Attachment "B."

4.7 Evaluation of Performance. Using the methods described above in this Section 4, Local Initiative shall evaluate Plan's performance of the Delegated Activities. Evaluation of Plan's performance shall include: (a) determining the extent to which Plan has performed in accordance with Plan's Program Documents, Local Initiative Program requirements, and relevant NCQA Standards as well as DHCS and DMHC standards; and (b) evaluating the results, outcomes or effects of Plan's performance of the Delegated Activities in relation to Local Initiative's expectations including, but not limited to, using information contained in the periodic reports described in Attachment "B."

4.8 Notification of Non-Compliance. Local Initiative shall notify Plan of any instance where, as a result of Local Initiative's oversight activities, Local Initiative determines that Plan's performance is not in compliance with Local Initiative's requirements or performance expectations or with NCQA Standards.

5. Compliance with Laws. At all times hereunder, Plan represents and warrants that: (a) it shall comply with all laws and regulations applicable to its performance of the Delegated Activities; (b) it has all licenses, certifications, registrations and any other types of permits required by law to perform the Delegated Activities; and (c) personnel who carry out the Delegated Activities shall

have appropriate training, and licensure, certification, registration or any other types of permits required by law. Plan shall notify Local Initiative promptly if making the determination that any of these representations was, is, or is reasonably likely to become inaccurate.

6. Assignment. Plan shall not assign this Delegation Agreement, or any interest herein or obligation hereunder, without the prior written consent of Local Initiative as provided in Article X of the Services Agreement. Plan shall not delegate or subcontract the performance of all or any portion of the Delegated Activities contemplated hereby to any third party without the prior written consent of Local Initiative as provided herein and as provided in Article IV of the Services Agreement.

7. Maintenance of Records. Plan shall maintain all information and records reviewed or created in connection with performing the Delegated Activities in accordance with Article IX of the Services Agreement and shall also permit Local Initiative and DHCS, DMHC, DHHS and DOJ to review and copy such information and records in accordance with the requirements of the law. Plan agrees to permit access to all pertinent information and records by regulatory agencies and accrediting bodies reviewing Local Initiative.

8. Corrective Action. If Local Initiative has reason to believe that Plan has not carried out the Delegated Activities in accordance with the terms of this Delegation Agreement, Local Initiative policies and procedures Local Initiative may take such steps as it deems necessary in accordance with Local Initiative polices and procedures, including but not limited to, the following:

8.1 Conduct an audit of Plan's performance of the Delegated Activities upon reasonable advance notice.

8.2 Require Plan to submit to Local Initiative, (within a reasonable time frame not to be less than thirty (30) days), a corrective action plan to address any non-compliance, or other problems identified by Local Initiative.

8.3 Require Plan to implement, a corrective action plan approved or developed by Local Initiative**.**

8.4 Terminate this Delegation Agreement as described in Article VII of the Services Agreement and Section 9 of this Delegation Agreement.

9. Termination. This Delegation Agreement may be terminated pursuant to the termination provisions of the Services Agreement.

10. Consequences of Termination or Expiration. Upon any termination of this Delegation Agreement in accordance with any provision hereof, or upon expiration of this Delegation Agreement at the end of the Term, the appointment shall terminate and all obligations of the parties shall immediately terminate, except as provided in Article VII of the Services Agreement.

11. Confidential Information and Covenants. The confidentiality provisions contained in Article X and Exhibit 8 (Protected Health Information) of the Services Agreement shall also apply to this Delegation Agreement.

12. Entire Agreement; Binding Effect. This Delegation Agreement along with the Services Agreement together contain the entire and final agreement between the parties hereto with respect to the subject matter hereof. No provision hereof may be modified, amended, or waived in any manner whatsoever other than by a supplemental writing signed by the parties hereto or their respective successors in interest. Subject to Sections 6 and 10, herein, this Agreement shall be binding upon and inure to the benefit of the parties and their respective successors, assigns, heirs, executors and legal representatives.

13. Waivers. The waiver by either party of any breach of any term, covenant, or condition contained herein shall not be deemed to be a waiver of any subsequent breach of the same or any other term, covenant, or condition contained herein. The subsequent acceptance of performance hereunder by a party shall not be deemed to be a waiver of any preceding breach by the other party of any term, covenant, or condition of this Delegation Agreement regardless of such party's knowledge of such preceding breach at the time of acceptance of such performance.

14. Severable Provisions; Headings. The provisions of this Delegation Agreement are severable, and if any one or more provisions are determined to be illegal or otherwise unenforceable, in whole or in part, the remaining provisions, and any partially unenforceable provision to the extent enforceable, shall nevertheless be binding and enforceable, unless it produces an inequitable result. The headings of paragraphs in this Delegation Agreement are for convenience only and shall not affect or limit the interpretation of its provisions.

15. Governing Law. This Delegation Agreement shall be governed by the law of the State of California.

16. Counterparts. This Delegation Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

17. Notices. Any and all notices required to be given hereunder may be given as provided for in Article X of the Services Agreement.

18. Dispute Resolution. The terms and conditions of the dispute resolution section of Article X of the Services Agreement shall also apply to any dispute under this Delegation Agreement.

19. Third Parties. Except as specifically provided herein, this Delegation Agreement does not, and is not intended to, create any rights in any person or entity that is not a party to this Delegation Agreement.

20. Definitions. The definitions in this Delegation Agreement have the same meaning as given in the Services Agreement. In the event of any conflict between the definitions contained in the

Services Agreement and the definitions contained in this Delegation Agreement, the definitions contained in this Delegation Agreement shall prevail.

Exhibit 10
NCQA Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("LA Care") to Plan ("Community Health Plan" or "CHP") and non-delegated activities retained by L.A. Care under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) utilization management, (iii) credentialing and recredentialing, and (iv) members' rights and responsibilities. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and regulatory requirements. CHP agrees to be accountable for all delegated activities set forth in Attachment A and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. CHP will provide periodic reports to L.A. Care as set forth in Attachment B. L.A. Care will oversee the delegation to CHP as described elsewhere in the Delegation Agreement. In the event deficiencies are identified on NCQA Standards for which CHP is delegated to perform through this oversight, CHP will provide a specific corrective action plan acceptable to L.A. Care. If CHP does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to CHP, in whole or in part.

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
QI 3 Health Services Contracting	Contracting with practitioners and provider organizations, including those making UM decisions, such that: 1. Contracts with practitioners require: a. Cooperation with QI activities b. Access to practitioner medical records to the extent permitted by applicable law c. Maintenance of confidentiality of member information and records. 2. Contracts with practitioners include an affirmative statement indicating that practitioners may freely communicate with patients about treatment regardless of benefit coverage limitations. 3. Contracts with provider organizations require: a. Cooperation with QI activities b. Access to provider medical records to the extent permitted by applicable law c. Maintenance of confidentiality of member information and records. 4. Contracts with specialists and specialty groups require timely notification to members affected by the termination of a specialist or the entire specialty group.	**X**	
QI 7 Complex Case Management (Effective 7/1/07)	Designing and implementing a complex case management structure for coordinating services for members with complex conditions that: 1. Identifies members for case management through a. Claims or encounters data, b. Hospital discharge data, c. Pharmacy data and d. Data collected through the UM process. 2. Provides members multiple avenues to be considered for case management services, including: a. Health information line referral, b. DM program referral, c. Discharge planner referral,	X	

[1] The Standards numbering in this Attachment relate to the 2007 NCQA MCO Standards and Guidelines unless noted otherwise.

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
	d. UM referral, e. Member self-referral, f. Practitioner referral. 3. Uses case management systems that support: a. Using evidence-based clinical guidelines or algorithms to conduct assessment and management, b. Automatic documentation of the individual and the date and time when the organization acted on the case or interacted with the member, and c. Automated prompts for follow-up (as required by the case management plan). 4. Includes case management procedures that address: a. Members' right to decline participation or disenroll from case management programs and services offered b. Initial assessment of members' health status, including condition-specific issues c. Documentation of clinical history, including medications d. Initial assessment of activities of daily living e. Initial assessment of mental health status, including cognitive functioning f. Initial assessment of life planning activities g. Evaluation of cultural and linguistic needs, preferences or limitations h. Evaluation of caregiver resources i. Evaluation of available benefits j. Development of a case management plan, including long and short-term goals k. Identification of barriers to meeting goals or complying with the plan l. Development of a schedule for follow-up and communication with the member m. Development and communication of self management plans for members. n. The process to assess progress against the case management plans for members. 5. Provides evidence that the Delegate has followed it documented processes for: a. Initial assessment of members' health status, including condition-specific issues b. Documentation of clinical history, including medications		

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
	c. Initial assessment of activities of daily living d. Initial assessment of mental health status, including cognitive functioning e. Initial assessment of life planning activities f. Evaluation of cultural and linguistic needs, preferences or limitations g. Evaluation of caregiver resources h. Evaluation of available benefits i. Development of a case management plan, including long and short-term goals j. Identification of barriers to meeting goals or complying with the plan k. Development of a schedule for follow-up and communication with the member l. Development and communication of self management plans for members. m. The process to assess progress against the case management plans and goals and modification of them as needed. 6. Annually evaluates member satisfaction with the case management program by: a. Obtaining feedback from members; and b. Analyzing member complaints and inquiries. 7. Measures the effectiveness of the case management program using at least three measures, each of which: a. Identifies a relevant process or outcome b. Uses valid methods that provide quantitative results c. Sets a performance goal has clearly identified measure specifications d. Analyzes results e. Identifies opportunities for improvement, if applicable f. Develops a plan for intervention and re-measurement 8. Based on the results of measurement and analysis a. Implements at least one intervention to improve performance; and b. Re-measures to determine performance.		
QI 8 Disease Management	Implementing two disease management programs for members with chronic conditions, including:	X	

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
Element A	1. Identifying two chronic conditions to be addressed by the disease management programs.		
Element B	2. Developing program content for each program that includes: a. Condition monitoring b. Patient adherence to the program's treatment plans c. Consideration of other health conditions d. Lifestyle issues as indicated by practice guidelines.		
Element C and D	3. Systematically, at least monthly, identifying members who qualify for the programs using the following data sources a. Claims or encounter data b. Pharmacy data c. Health risk appraisal results d. Laboratory results e. Data collected through the UM or case management process f. Member and practitioner referral.		
Element E	4. Providing members with written information regarding: a. How to use the services b. How members become eligible to participate c. How to opt in or out.		
	5. Providing interventions to members based on stratification.		
	6. Annually measuring member participation rates.		
Element F	7. Providing practitioners with written program information, including: a. Instructions on how to use the disease management services		
Element G	b. How the organization works with a practitioner's patients in the program.		
Element H	8. Integrating information from the following systems to facilitate access to member health information for continuity of care: a. A health information line. b. A DM program c. A case management program d. A UM program.		
Element I	9. Annually evaluating satisfaction with the DM services by a. Obtaining feedback from members b. Analyzing member complaints and inquiries.		
	10. Tracking one performance measure for each		

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
Element J Element K	program that: a. Addresses a relevant process or outcome b. Produces a quantitative result c. Is population based d. Uses data and methodology that are valid for the process or outcome measured e. Has been analyzed in comparison to a goal or benchmark.		
QI 9 Clinical Practice Guidelines	Adopting and disseminating clinical practice guidelines for the provision of non-preventive acute and chronic health care, including: 1. Ensuring that practitioners are using relevant clinical practice guidelines by: a. Adopting guidelines for at least four acute or chronic medical conditions, b. Establishing the clinical basis for the guidelines, c. Updating the guidelines at least every two years, and d. Distributing the guidelines to appropriate practitioners. 2. Ensuring that two of the adopted clinical practice guidelines are the clinical basis for the disease management programs described above. 3. Annually measuring performance against at least two important aspects of each of the four clinical practice guidelines.	X	

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
QI 10 Continuity and Coordination of Medical Care	Monitoring and taking action to improve continuity and coordination of medical care across the network by: 1. Notifying members affected by the termination of a primary care practitioner at least 30 calendar days prior to the effective termination date and helping the member select a new practitioner. 2. Allowing members continued access to practitioners whose contracts are discontinued: a. Through the current period of active treatment or for 90 calendar days, whichever is shorter, for members undergoing active treatment for a medical condition; and b. Through the postpartum period for members in their second or third trimester of pregnancy. 3. Developing and implementing a process for assisting members with transition of care when benefits end.	**X**	

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
QI 15 Sub-Delegation of QI	Further delegating (sub-delegating) and overseeing sub-delegation of quality management and improvement, which includes: 1. A written sub-delegation agreement between Delegate and Sub-delegate that: a. Is mutually agreed upon b. Describes the responsibilities of Delegate and Sub-delegate c. Describes the sub-delegated activities d. Requires at least semiannual reporting to Delegate e. Describes the process by which Delegate evaluates Sub-delegate's performance f. Describes the remedies, including revocation of the sub-delegation, available to Delegate if Sub-delegate does not fulfill its obligations. 2. The following provisions if the sub-delegation arrangement includes the use of protected health information by Sub-delegate: a. A list of the allowed uses of PHI b. A description of Sub-delegate safeguards to protect the information from inappropriate use or further disclosure c. A stipulation that Sub-delegate will ensure that further sub-delegates have similar safeguards d. A stipulation that Sub-delegate will provide individuals with access to their PHI e. A stipulation that Sub-delegate will inform Delegate if inappropriate uses of the information occur f. A stipulation that Sub-delegate will ensure that PHI is returned, destroyed, or protected if the sub-delegation agreement ends. 3. Evaluating and approving the Sub-delegate's QI program annually. 4. Evaluating the capacity of any new Sub-delegates before the delegation begins. 5. For sub-delegation arrangements in effect for 12 months or longer, Delegate:	**X**	

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
	a. Substantively evaluates the Sub-delegate's performance against relevant NCQA standards and Delegate's expectations annually. b. Evaluates regular reports from Sub-delegate at least semi-annually or more frequently based on the reporting schedule described in the sub-delegation document. c. Identifies and follows up on opportunities for improvement.		
UM 1 Utilization Management Structure	Evaluating and determining the appropriateness of the utilization of health care services and provision of needed assistance to clinician or patient in cooperation with other parties to ensure appropriate use of resources through prior authorization, concurrent review, retrospective review, discharge planning and case management, including: 1. A UM program description that addresses: a. Program structure b. Involvement of a designated senior physician in UM program implementation c. Program scope d. Processes and information sources used to make determinations of benefit coverage and medical necessity. 2. Evidence that a senior physician is actively involved in implementing the UM program. 3. An annual evaluation of the UM Program and updates, as necessary.	**X**	

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
UM 2 Clinical Criteria for UM Decisions	Adopting and using criteria for making UM decisions, including: 1. The following components: a. Written UM decision-making criteria that are objective and based on medical evidence. b. Written policies for applying the criteria based on individual needs. c. Written policies for applying the criteria based on an assessment of the local delivery system. d. Involvement of appropriate practitioners in developing, adopting and reviewing criteria. e. Annual review of UM criteria and the procedures for applying them based on individual needs and assessment of the local delivery system, and updating as necessary. 2. Making criteria available by: a. Informing practitioners in writing how they can obtain the UM criteria. b. Making the UM criteria available to practitioners upon request. 3. Ensuring consistency in applying the criteria by: a. At least annually, evaluating the consistency with which health care professionals involved in UM apply criteria in decision making. b. Acting on opportunities to improve consistency, if applicable.	**X**	
UM 3 Communication Services	Providing communication services for members and practitioners including: 1. Availability of staff at least eight (8) hours per day during normal business hours for inbound calls regarding UM issues. 2. Ability of staff to receive inbound communication regarding UM issues after normal business hours. 3. Staff sending outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. 4. Staff members identifying themselves by name, title, and organization name when initiating or returning calls regarding UM issues. 5. A toll-free number or staff who accepts collect calls regarding UM issues. 6. Access to staff for callers with questions about the UM process.	**X**	

NCQA Standard[1]	Delegated Activities	Delegated to CHP	Retained by L.A. Care
UM 4 Appropriate Professionals	Evaluating and determining the appropriateness of the utilization of health care services and provision of needed assistance to clinician or patient in cooperation with other parties to ensure appropriate use of resources through prior authorization, concurrent review, retrospective review, discharge planning and case management, including: 1. Written policies and procedures: a. Requiring that appropriately licensed professionals supervise all medical necessity decisions b. Specifying the type of personnel responsible for each level of UM decision-making. 2. A written job description with qualifications for practitioners who review denials of care based on medical necessity that requires: a. Education, training and professional experience in medical or clinical practice b. A current license to practice without restriction. 3. Ensuring that a physician, doctoral level health care practitioner, or pharmacist, as appropriate, reviews any non-behavioral health denial of coverage based on medical necessity. 4. Written procedures for using board certified consultants, and evidence that these procedures are used, to assist in making medical necessity determinations. 5. Distributing a statement to all members, practitioners, provider organizations, and employees who make UM decisions affirming that: a. UM decision-making is based only on appropriateness of care and service and existence of coverage b. Practitioners or other individuals are not rewarded for issuing denials of coverage, service, or care Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.	**X**	

UM 5 Timeliness of Utilization Management Decisions	Evaluating and determining the appropriateness of the utilization of health care services and provision of needed assistance to clinician or patient in cooperation with other parties to ensure appropriate use of resources through prior authorization, concurrent review, retrospective review, discharge planning and case management, including: 1. Adhering to the NCQA and State standards for timeliness of non-behavioral health UM decision making: a. Non-urgent pre-service b. Urgent pre-service c. Routine/Urgent concurrent d. Post service 2. Providing electronic or written notification of non-behavioral health UM decisions to practitioners and members of: a. Non-urgent pre-service denial b. Urgent pre-service denial c. Routine/Urgent concurrent denial d. Outpatient Service e. Post-service denial Note: L.A. Care and CHP must adhere to the applicable standards identified in the California Health & Safety Code and DHCS Contract, as well as the most recent NCQA MCO Standards.	**X**	

UM 6 Clinical Information	Evaluating and determining the appropriateness of the utilization of health care services and provision of needed assistance to clinician or patient in cooperation with other parties to ensure appropriate use of resources through prior authorization, concurrent review, retrospective review, discharge planning and case management, including: 1. A written description that identifies the information needed to support UM decision-making. 2. If onsite review services at facilities are provided, a documented process that includes: a. Guidelines for identifying Delegate staff at the facility in accordance with facility procedures b. A process for scheduling the onsite review in advance, unless otherwise agreed upon; and c. A process for ensuring that staff follows facility rules. 3. Documentation that relevant clinical information is gathered consistently to support non-behavioral health UM decision-making.	**X**	

NCQA Standard	Delegated Activities	Delegated to CHP	Retained by L.A. Care
UM 7 Denial Notices	Evaluating and determining the appropriateness of the utilization of health care services and provision of needed assistance to clinician or patient in cooperation with other parties to ensure appropriate use of resources through prior authorization, concurrent review, retrospective review, discharge planning and case management, including: 1. Notifying practitioners about Delegate's policy for making an appropriate practitioner reviewer available to discuss any UM denial decision and how to contact the reviewer. 2. Providing practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or other appropriate doctoral level reviewer. 3. Providing written notification of each non-behavioral health denial to the practitioner and member which includes: a. The specific reason for denial, in easily understandable language b. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based c. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request d. A description of appeal rights, including the right to submit written comments, documents or other information relevant the appeal e. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals f. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials.	**X**	

NCQA Standard	Delegated Activities	**Delegated to CHP**	Retained by L.A. Care
UM 8 Policies for Appeals	Developing written policies and procedures for thorough, appropriate and timely resolution of member appeals including: 1. Registering and responding to: a. Pre-service appeals b. Post-service appeals c. Expedited appeals d. External appeals. 2. For pre-service appeals, the following factors: a. Allowing at least 180 days after notification of the denial for the member to file the appeal b. Documenting the substance of the appeal and any actions taken c. Fully investigating the substance of the appeal, including any aspects of clinical care involved d. The opportunity for the member to submit written comments, documents or other information relating to the appeal e. Appointing a new individual to review the appeal, who was not involved in the initial determination and who is not the subordinate of any individual involved in the initial determination f. Appointing at least one individual to review the appeal who is a practitioner in the same or a similar specialty as that which typically treats the condition, performs the procedure or provides the treatment (for medical necessity appeals only) g. Making a decision and notifying the member within 30 calendar days of the receipt of a pre-service appeal h. Notifying the member about further appeal rights i. Procedures for providing to the member upon request, access to and copies of all documents relevant to the appeal j. Procedures for allowing an authorized representative to act on behalf of the member k. Procedures for expedited pre-service appeals, including the initiation, decision and notification process consistent with all	**X**	Members have the option to appeal directly to L.A. Care.

	applicable NCQA standards. 3. For post-service appeals, the following factors: a. Allowing at least 180 days after notification of the denial for the member to file the appeal b. Documenting the substance of the appeal and any actions taken c. Fully investigating the substance of the appeal, including any aspects of clinical care involved d. The opportunity for the member to submit written comments, documents or other information relating to the appeal e. Appointing a new individual to review the appeal, who was not involved in the initial determination and who is not the subordinate of any individual involved in the initial determination f. Appointing at least one individual to review the appeal who is a practitioner in the same or a similar specialty as that which typically treats the condition, performs the procedure or provides the treatment (for medical necessity appeals only) g. Making a decision and notifying the member within 60 calendar days of the receipt of a post-service appeal h. Notifying the member about further appeal rights i. Procedures for providing to the member upon request, access to and copies of all documents relevant to the appeal j. Procedures for allowing an authorized representative to act on behalf of the member. 4. Providing independent, external review of final determinations including: a. General communication to members at least annually announcing the availability of the right to independent review b. For eligible internal appeals where the determination is adverse to the member, specific written or electronic notification to members of the independent appeal rights and processes, including contact information for the IRO.		

UM 9 Appropriate Handling of Appeals	Evaluating and determining the appropriateness of appeals, including adjudicating member appeals in a thorough, appropriate and timely manner by: 1. Documenting the substance of appeals. 2. Investigating appeals. 3. Handling appeals in a timely manner by resolving: a. Pre-service appeals within 30 calendar days of receipt of the request b. Post-service appeals within 60 calendar days of receipt of the request c. Expedited appeals within 72 hours of receipt of the request. 4. Using non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. 5. Notifying members of: a. The specific reasons for the appeal decision in easily understandable language b. The benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based c. Their ability to obtain, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based d. Their ability to receive, upon request, reasonable access to, and copies of all documents relevant to their appeal e. The titles and qualifications, including specialties, of persons participating in the appeal review f. The next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures. 6. Providing in final internal denials: a. Member notification of independent appeal rights b. Member notification about obtaining more information regarding independent appeal rights c. A statement that members are not required to bear costs of the IRO including any filing fees.	X	Members have the option to appeal directly to L.A. Care.

	7. Implementing the IRO's decision in all overturned cases.		
UM 12 Emergency Services	Evaluating emergency department visits or claims, including: 1. Written policies and procedures that require: a. Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed; and b. Coverage of emergency services if an authorized representative, acting for Delegate, has authorized the provision of emergency services. 2. A review of presenting symptoms and discharge diagnoses by a physician or other appropriate doctoral level practitioner prior to denying or down-coding emergency department claims. 3. Coverage of emergency services when approved by an authorized representative.	**X**	
UM 13 Pharmaceutical Management	Implementing procedures for pharmaceutical management that promote clinically appropriate use of pharmaceuticals by including the following factors: 1. Policies and procedures for pharmaceutical management which include: a. The criteria used to adopt pharmaceutical management procedures b. A process that uses clinical evidence from appropriate external organizations. 2. Maintaining a list of pharmaceuticals (such as a formulary or preferred drug list) that includes restrictions and preferences and has policies that address: a. How to use the pharmaceutical management procedures b. An explanation of any limits or quotas c. An explanation of how prescribing practitioners must provide information to support an exceptions request d. The Delegate's process for generic substitution, therapeutic interchange, and	**X**	

	step-therapy protocols. 3. Addressing the following in procedures: a. Adoption or creation of a system for point-of-dispensing communications to identify and classify drug-drug interactions by severity b. Notification to dispensing providers at the point of dispensing of specific interactions that meet the Delegate's severity threshold c. Identification and notification of members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market within 30 calendar days of the FDA notification d. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. 4. Reviewing all pharmaceutical management procedures, and updating them as appropriate, at least annually and whenever new pharmaceutical information becomes available. 5. Involving pharmacists and appropriate practitioners in the development and periodic update of all pharmaceutical management procedures. 6. Providing pharmaceutical management procedures to practitioners at least annually and whenever changes are made. 7. Implementing policies and procedures for considering exceptions when a closed formulary is used, which include: a. Making exception requests based on medical necessity b. Obtaining medical necessity information from prescribing practitioners c. Using appropriate pharmacists and practitioners to consider exception requests d. Timely request handling e. Communicating the reason for any denial and an explanation of the appeals process when the Delegate does not approve an exception request.		

UM 15 Sub-Delegation of UM	Further delegating (sub-delegating) and overseeing sub-delegation of utilization management, which includes: 1. A written sub-delegation agreement between Delegate and Sub-delegate that: a. Is mutually agreed upon b. Describes the responsibilities of Delegate and Sub-delegate c. Describes the sub-delegated activities d. Requires at least semiannual reporting to Delegate e. Describes the process by which Delegate evaluates Sub-delegate's performance f. Describes the remedies, including revocation of the sub-delegation, available to Delegate if Sub-delegate does not fulfill its obligations. 2. The following provisions if the sub-delegation arrangement includes the use of protected health information by Sub-delegate: a. A list of the allowed uses of PHI b. A description of Sub-delegate safeguards to protect the information from inappropriate use or further disclosure c. A stipulation that Sub-delegate will ensure that further sub-delegates have similar safeguards d. A stipulation that Sub-delegate will provide individuals with access to their PHI e. A stipulation that Sub-delegate will inform Delegate if inappropriate uses of the information occur f. A stipulation that Sub-delegate will ensure that PHI is returned, destroyed, or protected if the sub-delegation agreement ends. 3. Evaluating the Sub-delegate's UM program annually.	**X**	
	4. Evaluating the capacity of any new Sub-delegates before the delegation begins. 5. For sub-delegation arrangements in effect for 12 months or longer, Delegate:		

	a. Substantively evaluates the Sub-delegate's performance against relevant NCQA standards and Delegate's expectations annually; b. Evaluates regular reports from Sub-delegate at least semi-annually or more frequently based on the reporting schedule described in the sub-delegation document. c. Identifies and follows up on opportunities for improvement.		

CR 1 Credentialing Policies	Documenting Delegate's process for credentialing and recredentialing licensed independent practitioners it employs or with whom it contracts and who fall within its scope of authority and action by: 1. Developing and implementing credentialing policies and procedures which specify: a. The types of practitioners to credential and recredential b. The verification sources used c. The criteria for credentialing and recredentialing d. The process for making credentialing and recredentialing decisions e. The process for managing credentialing files that meet Delegate's established criteria	**X**	

	f. The process to further delegate (sub-delegate) credentialing or recredentialing g. The process used to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner h. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner i. The process to ensure that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision j. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program k. The process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law l. The process for ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty. 2. Including the following practitioner rights in policies and procedures: a. The right of practitioners to review information submitted to support their credentialing application b. The right of practitioners to correct erroneous information c. The right of practitioners to be informed of the status of their credentialing or recredentialing application, upon request d. Notification of practitioners of these rights.		

CR 2 Credentialing Committee	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: 1. The committee: a. Includes representation from a range of participating practitioners. b. Has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers. 2. The Medical Director or equally qualified individual reviews and approves files that meet the Delegate's established criteria.	**X**	
CR 3 Initial Credentialing Verification	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to initial credentialing: 1. Current, valid license to practice. 2. A valid DEA or CDS, if applicable. 3. Education and training, including board certification if practitioner states on the application that he or she is board certified, as well as expiration date of certification. 4. Work history. 5. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner.	**X**	
CR 4 Application and Attestation	Primary source verification and credentialing and recredentialing decision-making, which includes using an application and signed attestation which address: 1. Reasons for inability to perform the essential functions of the position, with or without accommodation. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary action. 5. Current malpractice insurance coverage. 6. The correctness and completeness of the application.	**X**	

CR 5 Initial Sanction Information	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to initial credentialing: 1. State sanctions, restrictions on licensure, and limitations on scope of practice. 2. Medicare and Medicaid sanctions.	**X**	
CR 7 Recredentialing Verification	Primary source verification and credentialing and recredentialing decision-making, which includes: 1. Verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to recredentialing: a. Current, valid license to practice b. A valid DEA or CDS certificate, as applicable c. Board certification for practitioners who acquired additional board certification since last credentialed or who state that they are board certified and records from the prior credentialing cycle indicate board certification has expired, including board certification expiration date. d. History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner	**X**	
CR 7 Recredentialing Verification	e. State sanctions, restrictions on licensure, and/or limitations on scope of practice f. Medicare and Medicaid sanctions. 2. Obtaining a completed, current, and signed recredentialing application and attestation that addresses: a. Reasons for any inability to perform the essential functions of the position, with or without accommodation b. Lack of present illegal drug use c. History of loss of license and felony convictions d. History of loss or limitation of privileges or disciplinary action e. Current malpractice insurance coverage f. Correctness and completeness of application.		

CR 8 Recredentialing Cycle Length	Recredentialing all practitioners at least every 36 months.	**X**	
CR 9 Ongoing Monitoring	Developing and implementing policies and procedures for ongoing monitoring and appropriate interventions between recredentialing cycles including: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions and imitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when Delegate identifies instances of poor quality.	**X**	
CR 10 Notification to Authorities and Practitioner Appeal Rights	Using objective evidence and patient care considerations to decide on altering a practitioner's relationship with Delegate if the practitioner does not meet Delegate's quality standards, including: 1. Developing and implementing policies and procedures that include: a. The range of actions available to Delegate b. Reporting to authorities c. A well-defined appeal process d. Making the appeal process known to practitioners. 2. Reporting practitioner suspensions and terminations to appropriate authorities. 3. Offering the appeal process to practitioners when Delegate chooses to alter the conditions of practitioners' participation based on issues of quality of care or service.	**X**	
CR 11 Assessment of Organizational Providers	Assessing and approving, initially and in an ongoing manner, provider organizations, by: 1. Developing and implementing policies and procedures that confirm: a. That the provider organization is in good standing with state and federal regulatory bodies b. That the provider organization has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable c. An onsite quality assessment is conducted if the provider organization is not accredited by an accrediting body acceptable to Delegate	**X**	

	d. At least every three years that the provider organization continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate 2. Including in the assessment and approval process the following medical provider organizations: a. Hospitals b. Home health agencies c. Skilled nursing facilities d. Freestanding surgical centers. 3. Completing and documenting assessments of all contracted medical health care provider organizations.		
CR 12 Sub-Delegation of CR	Further delegating (sub-delegating) and overseeing sub-delegation of credentialing, which includes: 1. A written sub-delegation agreement between Delegate and Sub-delegate that: a. Is mutually agreed upon b. Describes the responsibilities of Delegate and Sub-delegate c. Describes the sub-delegated activities d. Requires at least semiannual reporting to Delegate e. Describes the process by which Delegate evaluates Sub-delegate's performance f. Describes the remedies, including revocation of the sub-delegation, available to Delegate if Sub-delegate does not fulfill its obligations. 2. The following provisions if the sub-delegation arrangement includes the use of protected health information by Sub-delegate: a. A list of the allowed uses of PHI b. A description of Sub-delegate safeguards to protect the information from inappropriate use or further disclosure c. A stipulation that Sub-delegate will ensure that further sub-delegates have similar safeguards d. A stipulation that Sub-delegate will provide individuals with access to their PHI e. A stipulation that Sub-delegate will inform Delegate if inappropriate uses of the information occur f. A stipulation that Sub-delegate will ensure that PHI is returned, destroyed, or protected if the sub-delegation agreement ends. 3. Retention of the right by Delegate and LA Care,	**X**	

	based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. 4. Evaluating the capacity of any new Sub-delegates before the sub-delegation begins. 5. For sub-delegation arrangements in effect for 12 months or longer, Delegate: a. Audits credentialing files against NCQA standards annually b. Substantively evaluates the sub-delegated activities against relevant NCQA standards and Delegate's expectations annually c. Evaluates regular reports from Sub-delegate at least semi-annually or more frequently based on the reporting schedule described in the sub-delegation document d. Identifies and follows up on opportunities for improvement.		
RR 3 Policies for Complaints and Appeals	Developing and implementing written policies and procedures for thorough, appropriate and timely resolution of member complaints and appeals, including: 1. Policies and procedures for registering and responding to oral and written complaints which include the following factors: a. Documenting the substance of the complaint and actions taken b. Investigating the substance of the complaint, including any aspects of clinical care involved c. Notifying the member of the disposition of the complaint and the right to appeal, as appropriate d. Standards for timeliness in responding to complaints that accommodate the clinical urgency of the situation 2. Policies and procedures for registering and responding to written appeals which include the following factors: a. Documenting the substance of the appeal and actions taken b. Investigating the substance of the appeal, including any aspects of clinical care involved c. Notifying the member of the disposition of the appeal and the right to further appeal, as appropriate d. Standards for timeliness in responding to	**X**	Members have the option to complain and appeal directly to L.A. Care.

	appeals that accommodate the clinical urgency of the situation.		
RR 4, Element B Interpreter Services	Providing interpreter/bilingual services in the customer services and telephone function based on linguistic needs of members.	**X**	

Exhibit 10
NCQA Delegation Agreement
Attachment B

Plan's Reporting Requirements

1. Local Initiative shall provide Plan with report specifications, in both electronic and hard copy formats, for the reports listed below for review and approval.

Report	Due Date	Submit To	Required Format
Member Services **1. Member Complaint and Appeals Log** **2. Member Complaint per 1,000** **3. Member Appeals per 1,000** **4. Member Complaints by Category** **5. Member Appeals by Category** **6. Member Appeals Timeliness**	Monthly 12th business day of each month	**Elsie Eng** **Member Services Department** **eeng@lacare.org**	**Current reporting format acceptable**
Telephone Call Center Statistics **1. Number of Calls Answered within 30 seconds by a non-recorded voice** **2. Average Speed of Answer (seconds)** **3. Calls Answered within 30 Seconds – (percentage)** **4. Abandonment Rate - %**	Monthly 12th business day of each month	**Iris Mejia** **Member Services Department** **imejia@lacare.org**	**Current reporting format acceptable**
Service Authorizations and Utilization Review **1. UM Program Description/Work Plan** **2. UM Program Evaluation**	Annually Feb 25th	**Kathleen Rice** **UM Dept** **krice@lacare.org**	**Narrative**
3. UM Program Work Plan Updates **4. UM Summary – Inpatient Activity** **a. Average monthly membership** **b. Acute Admissions/K** **c. Acute Bed days/K** **d. Acute LOS** **e. Acute Readmits/K** **f. SNF admissions/K** **g. SNF Bed days/K** **h. SNF LOS** **i. SNF Readmits/K**	Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	**Kathleen Rice** **UM Dept** **krice@lacare.org**	**L.A. Care Quarterly Reporting Format**

Report	Due Date	Submit To	Required Format
5. UM Activities Summary[2] **a. Referral Management** **b. Tracking of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent)** **c. Referral Denial Rate** **d. Specialty Referrals** **e. Unusual Specialty Referrals** **f. Standing Referrals** **g. Investigational/Experimental** **h. Second Opinion** **i. Hospice** **j. Independent Medical Review** **k. Appeals/K** **l. Overturn Rate**	Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	**Kathleen Rice** **UM Dept** **krice@lacare.org**	**L.A. Care Quarterly Reporting Format**
Pharmacy **1. Need reporting on additional delegated activities** **2. Pharmacy Activities Summary** **a. Denials per 1,000** **b. Appeals/K** **c. Overturn Rate**	Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	**Camy Porro** **Pharmacy Dept** **Cporro@lacare.org**	**L.A. Care Quarterly Reporting Format**
Network Management **1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name.** **2. Recredentialed practitioner list containing Recredentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name.** **3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name.** **4. Involuntary Practitioner Termination list**	Quarterly 1st Qtr – April 15 2nd Qtr – July 15 3rd Qtr – Oct 15 4th Qtr – Jan 15	**Susan Williams** **Credentialing Dept** **cwilliams@lacare.org**	**L.A. Care Quarterly Reporting Format**

[2] Delegate must be able to provide detailed information upon request within a reasonable timeframe.

Report	Due Date	Submit To	Required Format
containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name			
Disease Management Reporting Data **L.A. Care and CHP will mutually agree upon the content of the required reporting within six (6) months of the effective date of this Agreement. Both parties agree that every effort will be made to use standard reports from CHP's contracted vendor.**	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 15 4th Qtr – Feb 25	**Maria Casias** **QI Specialist** **mcasias@lacare.org**	**Vendor reporting approved by CHP**
Complex Case Management Reporting **L.A. Care and CHP will mutually agree upon the content of the required reporting within six (6) months of the effective date of this agreement. Both parties agree that every effort will be made to use standard reports from CHP's contracted vendor.**	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 15 4th Qtr – Feb 25	**Maria Cassias** **QI Specialist** **mcasias@lacare.org**	**Vendor reporting approved by CHP**